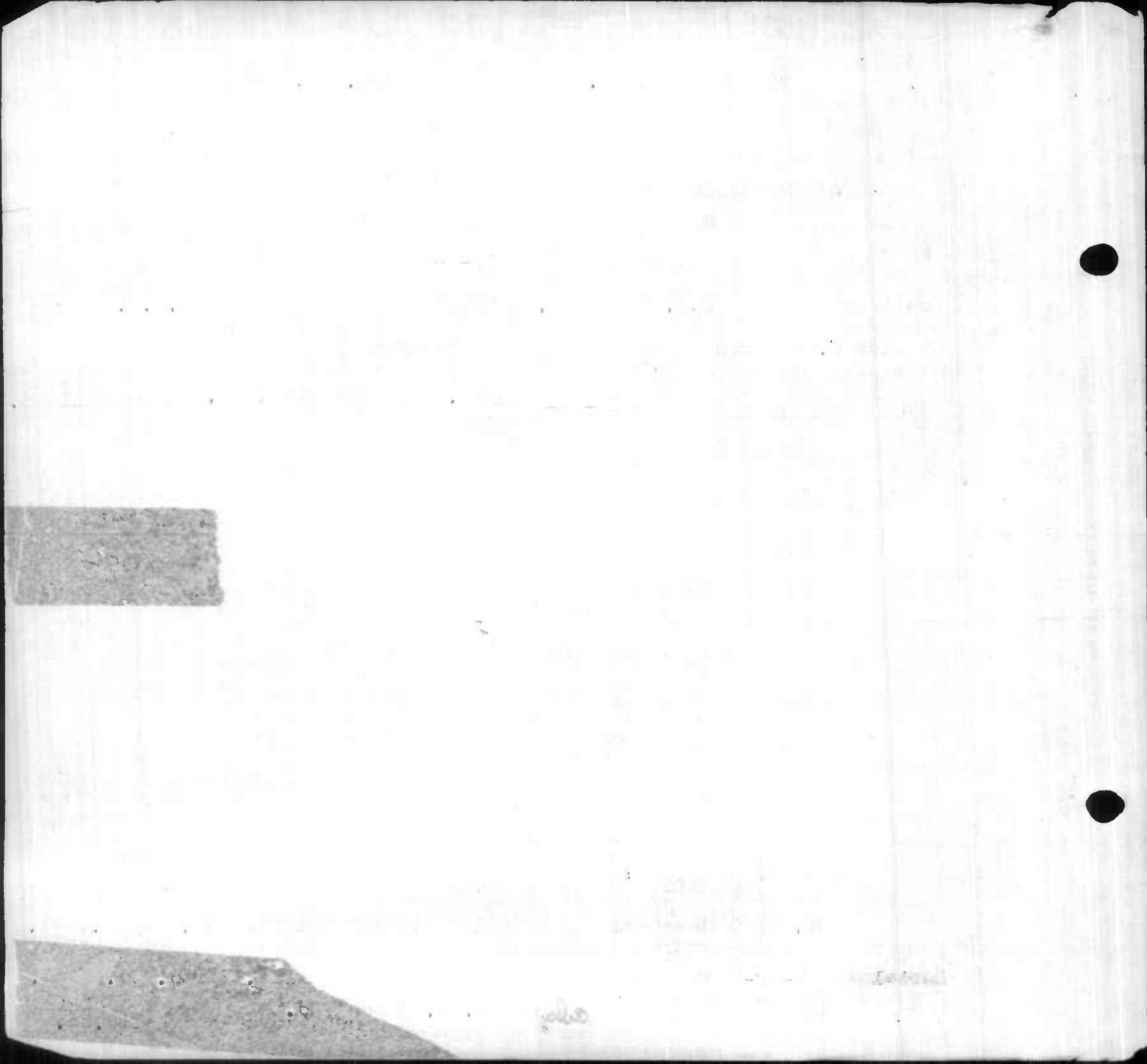


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

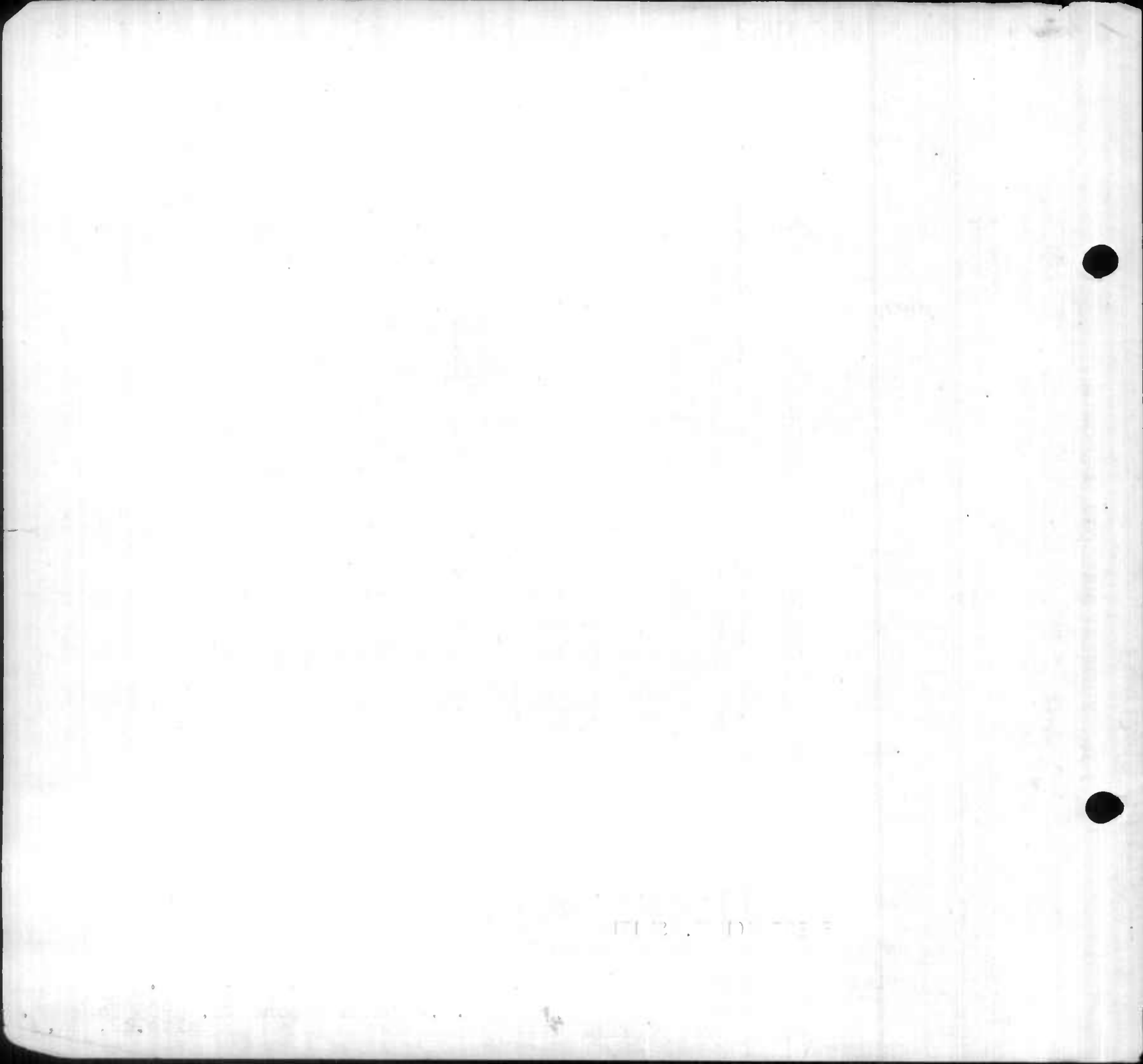
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1001 | |
|---|---|--|--|---|---|---|--|
| W. 420 90 | | BIRTH NO. 65 1001 | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | David Wallace, Sr. | | 2. DATE AND HOUR OF DEATH Jan. 26, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Anderson Nursing Home | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3401 Greenway | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 10-8-1889 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President | | 10B. KIND OF BUSINESS OR INDUSTRY J.S. Young Co. | | 11. BIRTHPLACE (State or foreign country) Scotland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles H. Wallace | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-01-7446 | | 17. INFORMANT Mr. David Wallace, Jr. ADDRESS 3910 Cloverhill Rd. | | | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) <i>Chronic Arterio Sclerotic Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH 10 yrs (B) <i>Cerebral Vascular Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH 8 hrs (C) <i>Chronic Bronchitis</i> INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | | | |
| | | 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Generalized Arterio Sclerosis | | | | | |
| | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| | | 19A. DATE OF OPERATION 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 6 - 1962 to Jan 26 - 1965 , that (I) was lost saw the deceased alive on Jan 26 - 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. 6:40 P.M. - | | | | | | | |
| 23A. SIGNATURE Earl L. Chambers | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Earl Chambers | | | | 23D. ADDRESS M.D. 4108 Liberty Heights Ave. Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-29-1965 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR H. W. & Sons Co. | | ADDRESS 21212 4905 York Road Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

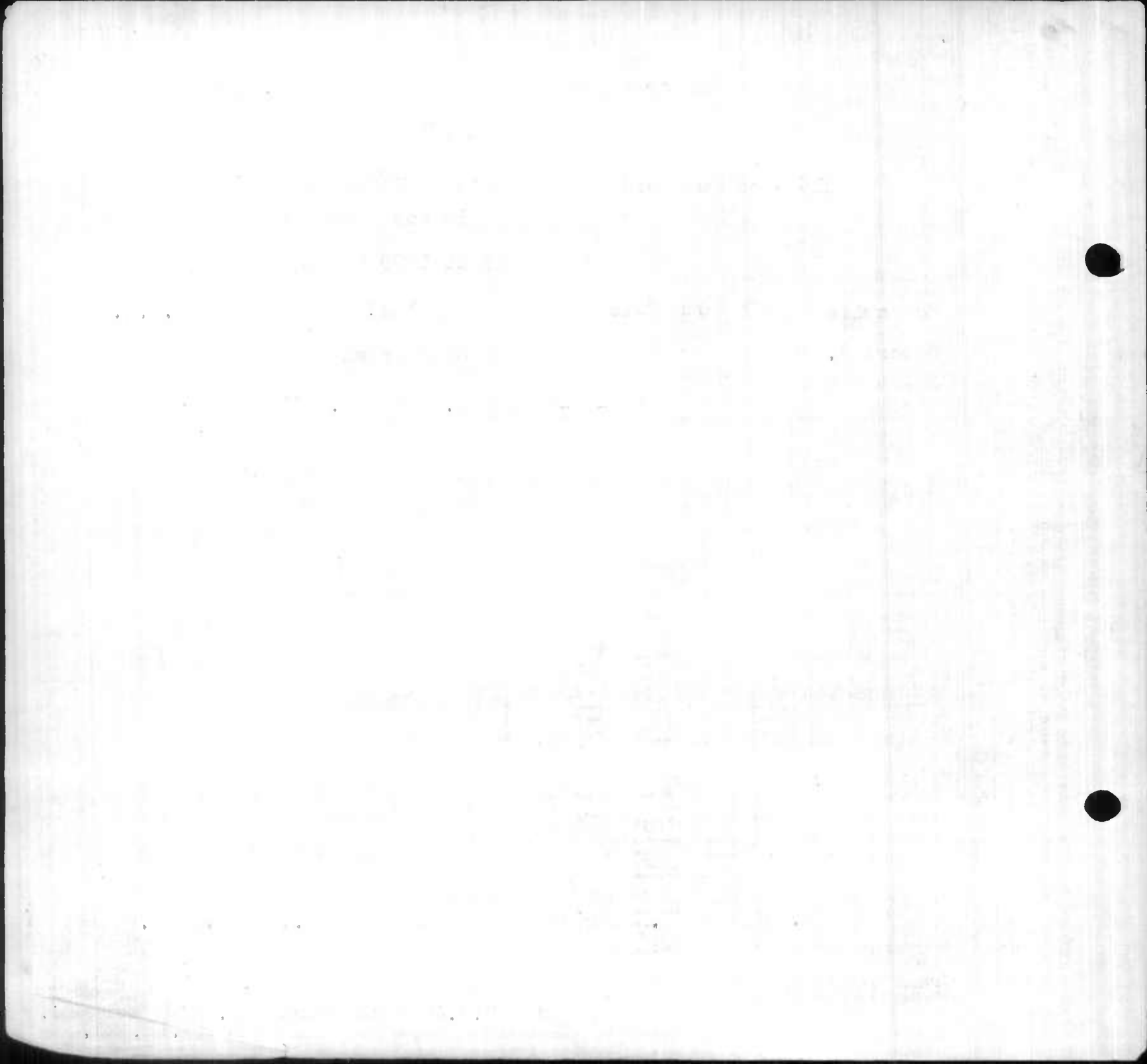
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1002 | |
|---|-----------|---|--|--|--|---|-----------------------------|--|---|------------------------|--|
| BIRTH NO. 65 1002 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ALMA M. HELLER | | | | | 2. DATE AND HOUR OF DEATH 26 JANUARY 65 11:30 P.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | | | A. STATE MD B. COUNTY BALTIMORE | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 537 E. 36 ST | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | | 8. DATE OF BIRTH 12/1/90 | 9. AGE (In years lost birthday) 74 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY N/A | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME WILLIAM BENNY | | | | | 14. MOTHER'S MAIDEN NAME MARY BREGEL | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO N/A | | | 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT E.O. SMITH, MD | | | ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cong Heart Failure | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) Myocardial Infarction, old (B) Pulmonary Atelectasis | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION NONE | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? N/A | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 30 19 64 to JANUARY 26 19 65, that (I) (we) lost saw the deceased alive on JANUARY 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Frederick O. Smith | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 26 JAN 65 | | | |
| 23C. PHYSICIAN'S NAME (Type) FREDERICK O. SMITH | | | | | 23D. ADDRESS UNION MEMORIAL HOSP | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1/30/1965 | | 24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | ADDRESS 4905 York Rd. Balto. 12, Md. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

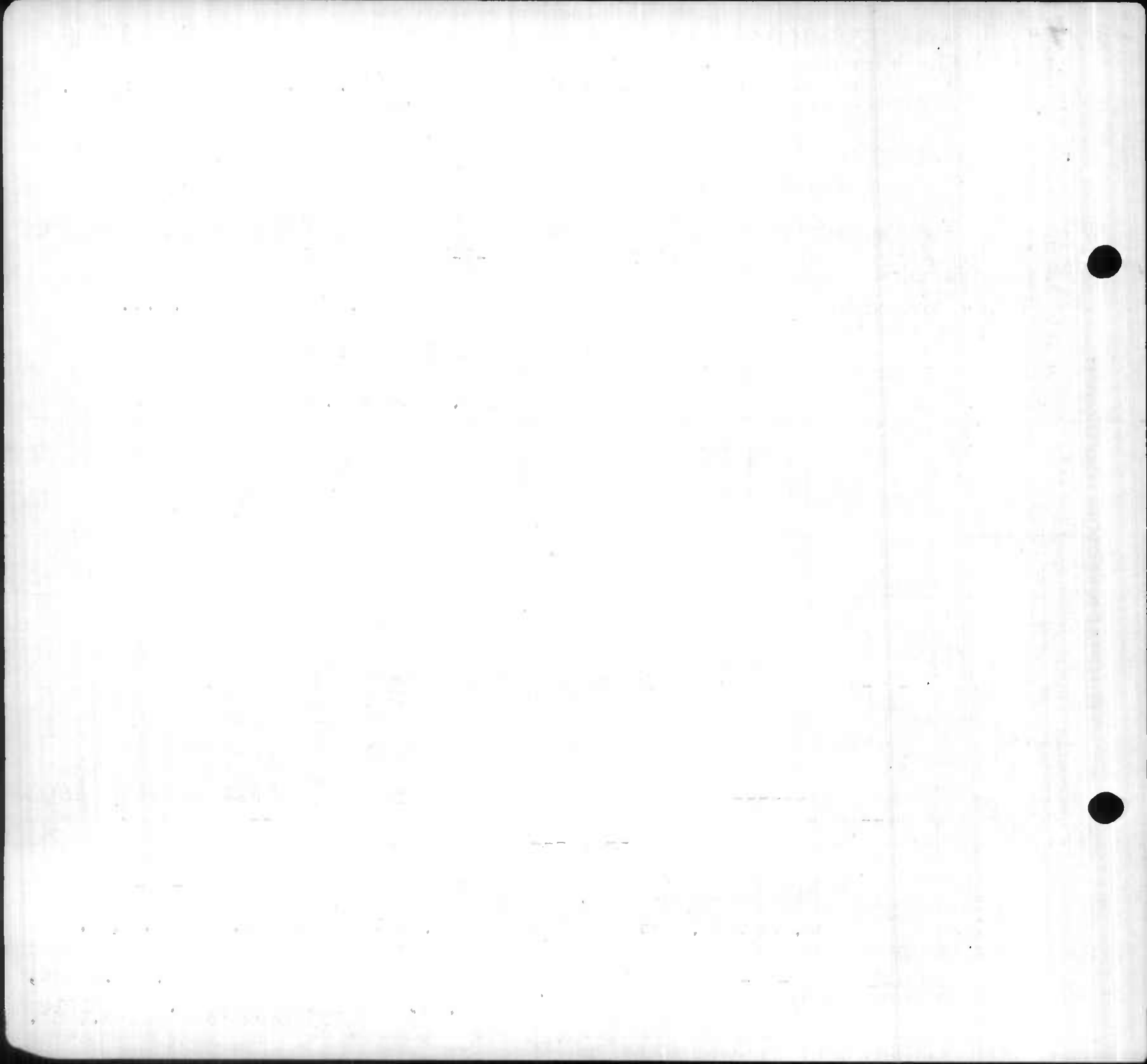
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1003 | |
|---|--------------|--|--|---|--|
| BIRTH NO. 65 1003 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Louise Shafer Kurtz | | January 26, 1965 7:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 215 Woodlawn Road | | | A. STATE Maryland B. COUNTY 27-14 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 215 Woodlawn Road | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12/16/1899 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Robert F. Shafer | | | 14. MOTHER'S MAIDEN NAME Mary Helen Orndorf | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-44-3605 | 17. INFORMANT Mrs. Louise K. Shultz (Same) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Arteriosclerosis</u> (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 64 to January 26 19 65, that (I) (we) last saw the deceased alive on January 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Dr. William G. Helfrich</i> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich | | | | 23D. ADDRESS 5006 Roland Ave., Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 1/29/1965 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

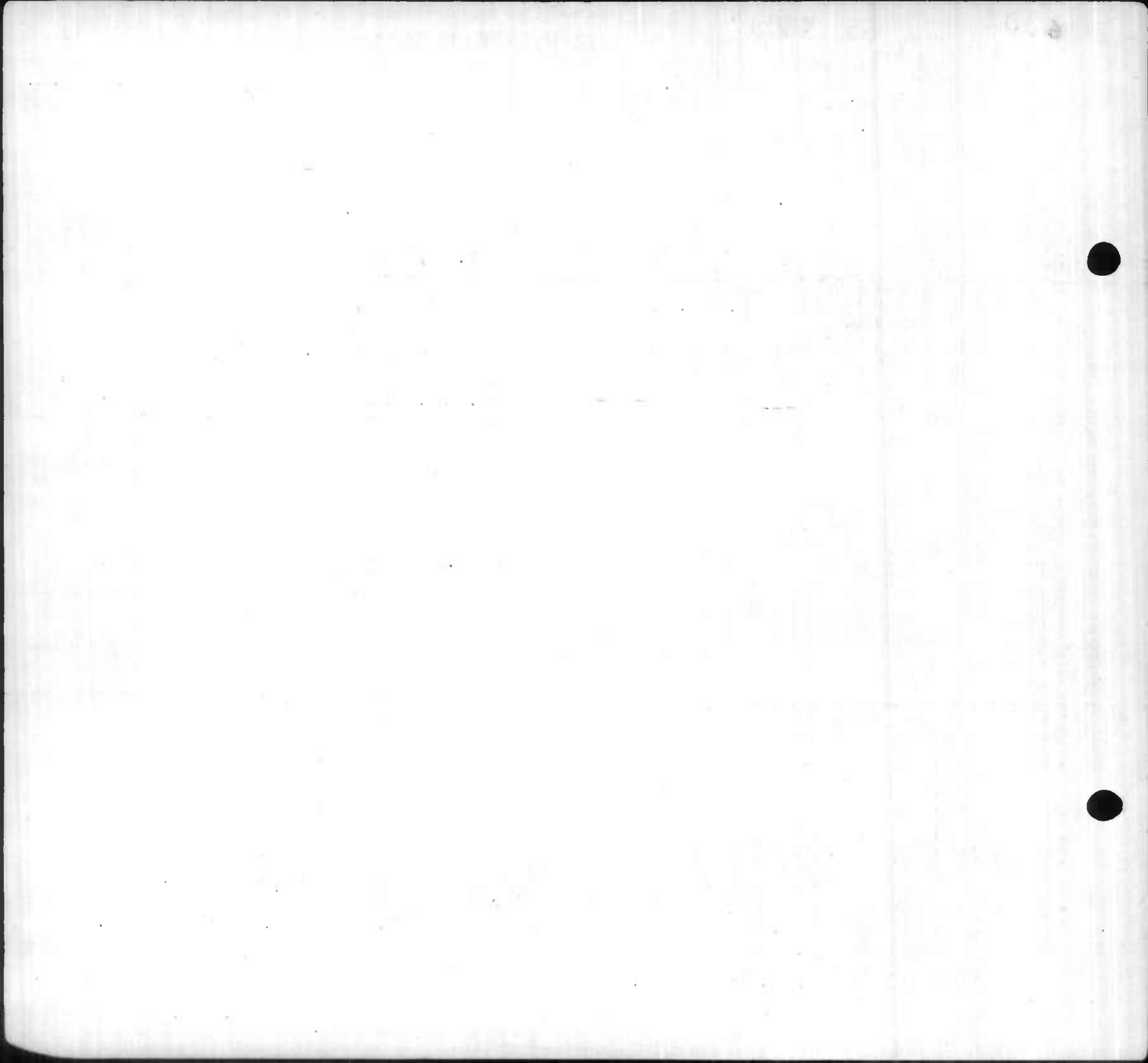
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--------------|---|---|---------------------------------------|---|--|-----------------------------|---|---|--|
| BIRTH NO. 65 1004 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 1004 | | |
| 1. NAME OF DECEASED (Type or Print) Elizabeth Adams Hoff | | | | | 2. DATE AND HOUR OF DEATH Jan. 26, 1965 4:10 p. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 224 Wendover Road | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 224 Wendover Road | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-3-1903 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) King George, Va. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Rodger Boggs | | | | | 14. MOTHER'S MAIDEN NAME Lillian Gouldman | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. Arthur L. Hoff | | | ADDRESS Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Adenocarcinoma of Brain (Original site unknown) Carcinomatosis (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years ? | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION 9-29-64 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor adjacent to brain | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? _____ | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from September 14 19 49 to January 26 19 65, that (I) (we) last saw the deceased alive on January 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>John M. Scott</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 1-27-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. John M. Scott | | | | | 23D. ADDRESS M.D. 600 W. Belvedere Ave. Balto., Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-28-1965 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | | | 24D. LOCATION (City, town, or county) (State) Pikesville Balto. Co., Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | | | ADDRESS 4905 York Road Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

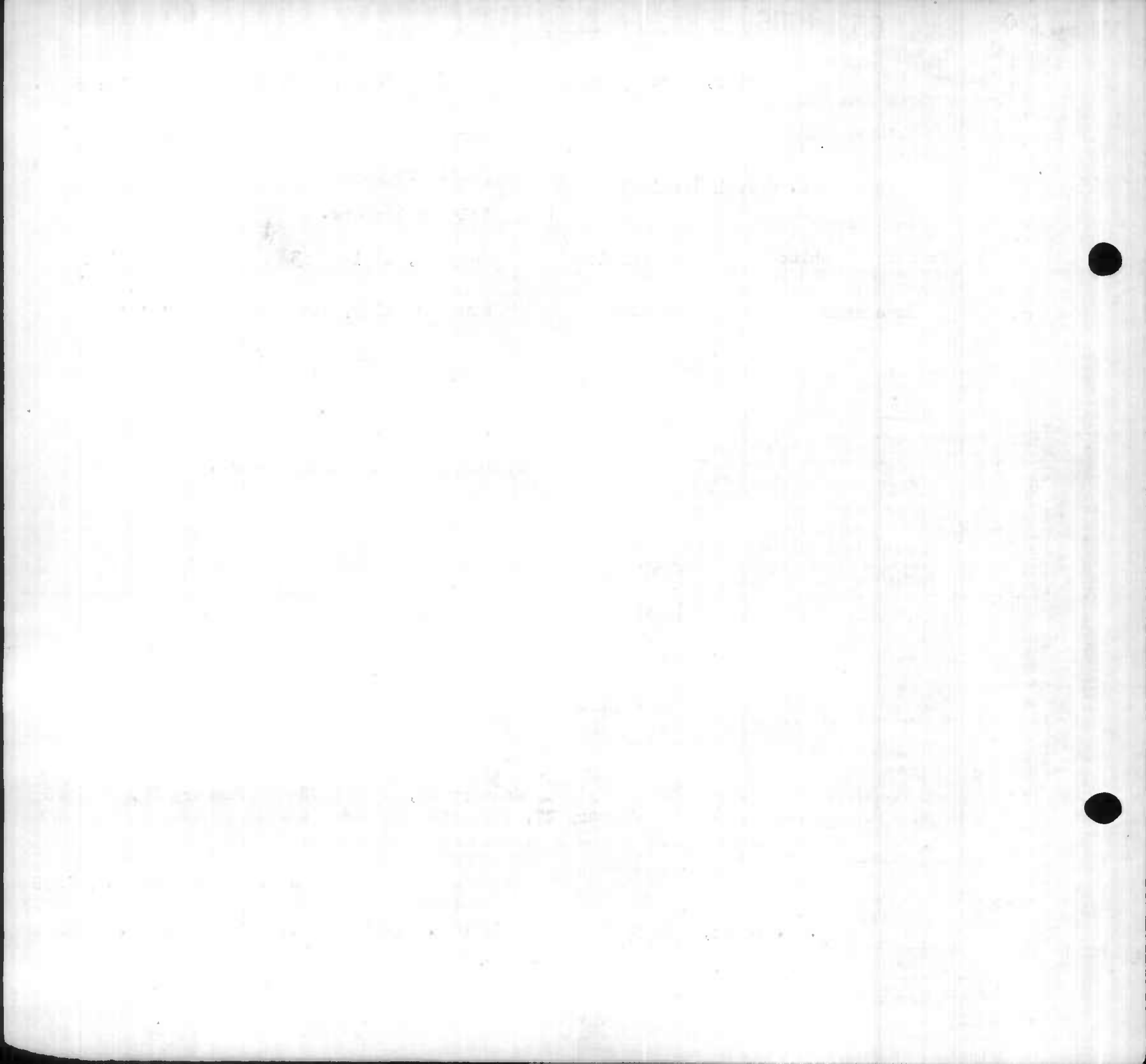
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1005 | |
|--|---------|--|--|--|--|
| BIRTH NO. 65 1005 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) EMMA S. DEALE | | | | January 25, 1965, 6.00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2707 St. Paul Street | | | | A. STATE B. COUNTY Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21218 | |
| | | | | D. STREET ADDRESS (If rural, give location) 2707 St. Paul Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Female | White | Single | Nov. 13, 1888 | 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Hat Designer, Dept. Store. | | | Baltimore, Maryland | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John William Deale | | | Rosella R. Grimes | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No --- 213-01-7923 | | | Wm. W. M. Deale | | 219 Melancton Rd. Lutherville Md. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Coronary Thrombosis</u> DUE TO (B) <u>Arteriosclerosis + myocarditis</u> DUE TO (C) <u>Bronchial Asthma</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Indefinite</u> <u>over 6 years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>56</u> to <u>January 25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>January 22</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Nathaniel M. Beck M.D.</u> | | | | 23B. DATE SIGNED Jan. 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Nathaniel M. Beck | | | | 23D. ADDRESS 2818 St. Paul St. Baltimore Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | Jan. 28. 1965 | | St. Barnabas Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 28 1965 | | Robert E. Taylor, M.D. | | HENRY SANDER & SONS, INC. Baltimore Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. LOCATION (City, town, or county) (State) | | | |
| Leeland | | Prince George's County. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

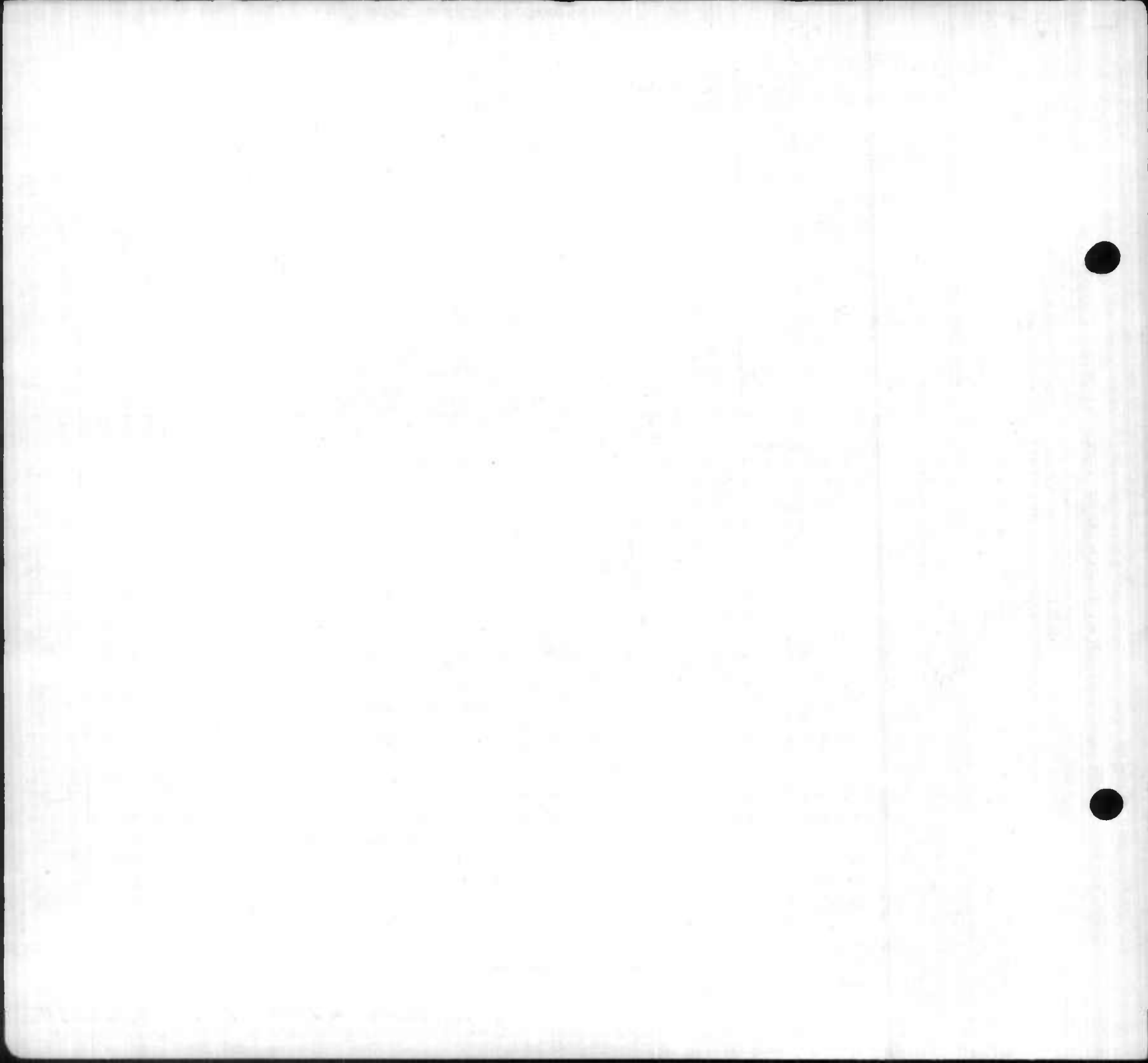
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1006 | |
|---|-----------|--|---|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. 65 1006 | |
| BIRTH NO. 65 1006 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | Meier, Cora (CORA MAY MEIER) | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH | | January 27, 1965 10:45 A.M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| St. Joseph Hospital | | Maryland | | Baltimore 21234 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 2510 Taylor Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthd) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Female | White | Married | July 25, 1881 | 83 | Homemaker |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Homemaker | | Own Home | New York City, New York | U.S.A. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William Rovecamp | | | Lillian Knapp | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | 218 46 1350 | Mr Charles F. Meier 2510 Taylor Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | (A) Metastatic carcinoma of breast. | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 24, 19 65 to January 27, 19 65, that (I) (we) last saw the deceased alive on January 27, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| B. B. Velez, | | | | January 27, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| B. B. Velez, | | M.D. 1400 N. Caroline St., Baltimore, Md. 21213 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | 1/30/65 | Loudon Park | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 28 1965 | | Robert E. Taylor, M.D. | | HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

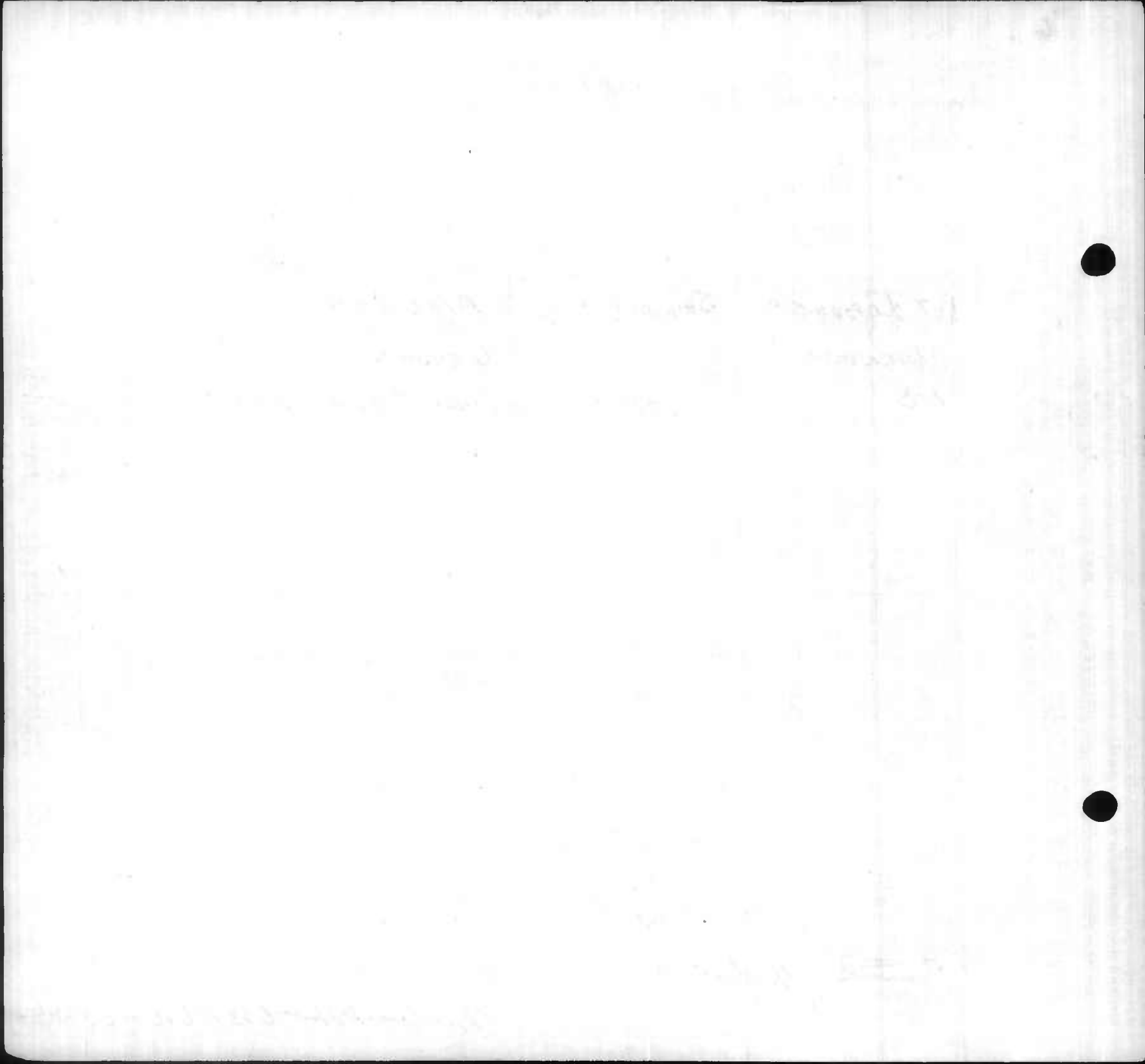
| | | | | | |
|---|--------------|--|---|--|---|
| BIRTH NO. 65 1007 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1007 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) PINDER, GEORGE LAWRENCE | | | 2. DATE AND HOUR OF DEATH 1-26-65 5.10 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Aniversity Hospital | | | A. STATE Md. B. COUNTY 17-02 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 1313 MYRTLE AVE., # 21217 | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 4-14-1900 | 9. AGE (In years last birthday) 64 | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER | | 10B. KIND OF BUSINESS OR INDUSTRY CATERER | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME JOHN PINDER | | | 14. MOTHER'S MAIDEN NAME SADIE FRANCIS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 30-21-1913 | | 17. INFORMANT Esther Pinder 1313 Myrtle Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, arising rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH CARDIAC ARREST | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC HEART DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 1-26-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC INSUFFICIENCY | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-6 - 19 65 to 1-26 - 19 65, that (I) (we) last saw the deceased alive on 1-26 - 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Roman Herman | | | | 23B. DATE SIGNED 1-26-65 | |
| 23C. PHYSICIAN'S NAME (Type) ROMAN HERMAN | | | | 23D. ADDRESS Aniversity Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. STATE Md | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Wm. H. Hayes 638 B. Johns St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

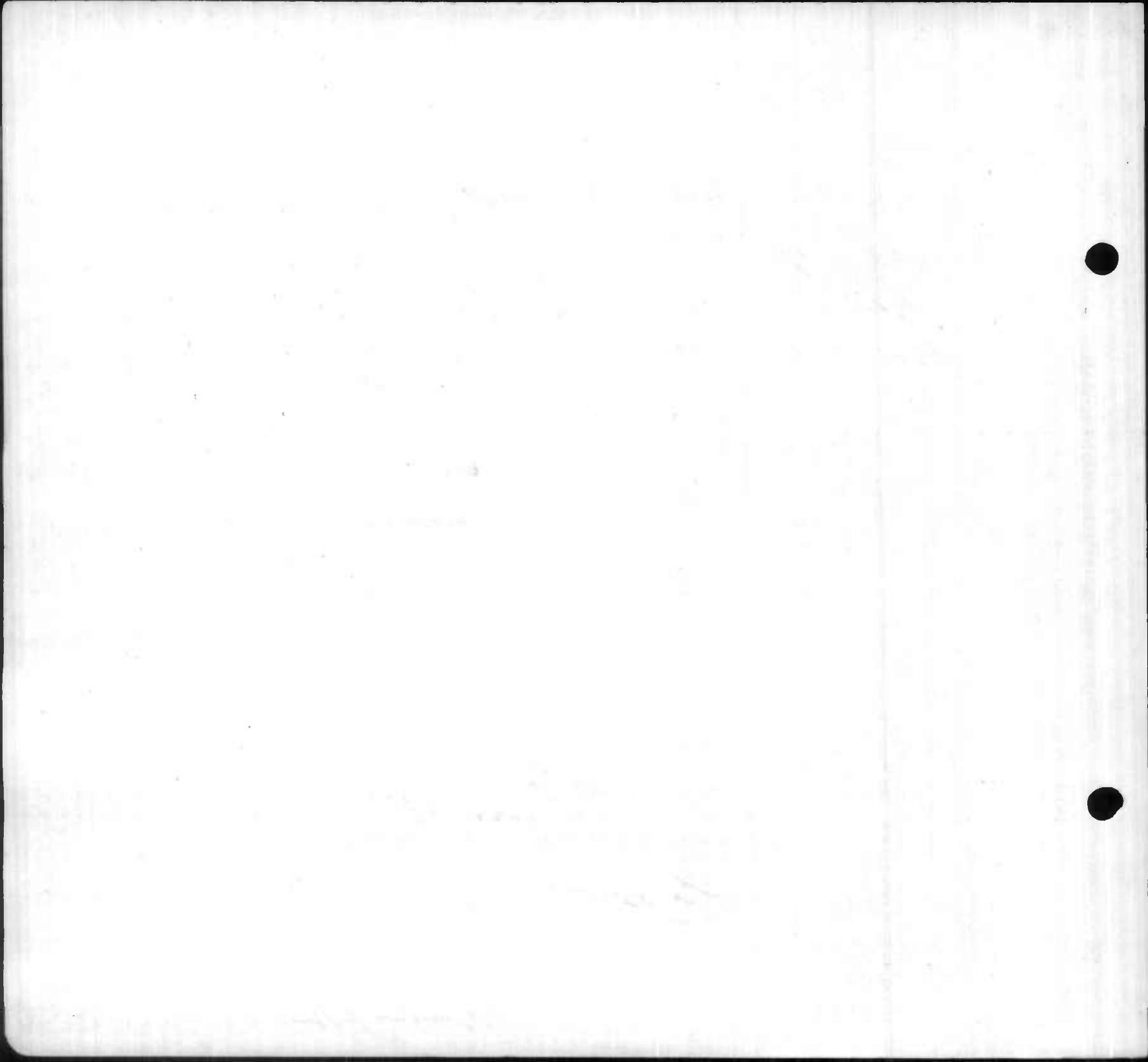
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------|---|------------------|---|---|
| BIRTH NO. | | 65 1008 | | 65 1008 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Young, Percy | | 2. DATE AND HOUR OF DEATH 1/25/65 1 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | A. STATE Maryland B. COUNTY Balt. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 234 N. Gilmore St. | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 82 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY SHIPYARD - | | 11. BIRTHPLACE (State or foreign country) ALABAMA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 171-10-2496 | | 17. INFORMANT LULA BUSBY 234 N Gilmore St | |
| 18. 204.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Chronic lymphatic leukemia DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Yes | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25/65 12 PM 19 to 1/25/65 1 PM 19, that (II) (we) last saw the deceased alive on 1/25/65 1 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David W. Morse | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) David W. Morse | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION Baltimore | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | 25B. NAME OF REGISTRAR R. E. Fisher | | 25C. FUNERAL DIRECTOR Margaret Kelley 638 N Gilmore St | |



FUNERAL DIRECTOR: IMPORTANT

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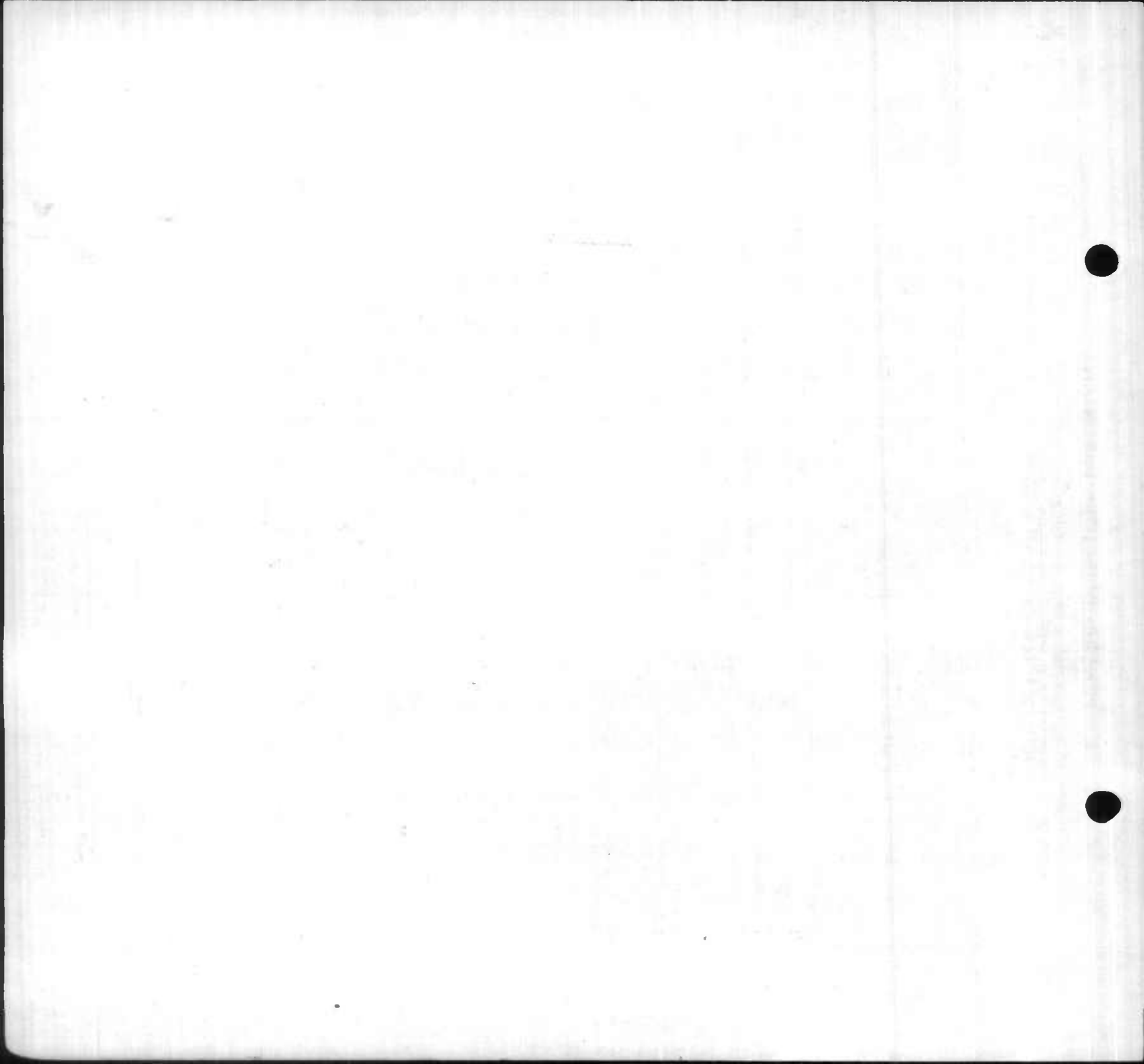
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. | |
|--|--------------|--|--------------------|---|-----------------------------|--|------------------------------|
| 65 1009 | | | | | | 65 1009 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Boatwright - Marvion</i> | | | | 4 AM 1-27-65 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| <i>Lutheran Hospital of Maryland</i> | | | | <i>Maryland</i> | | <i>16-05</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | <i>2572 Edmondson Ave</i> | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| <i>Female</i> | <i>negro</i> | <i>married</i> | <i>Sept 5-1906</i> | <i>58 yrs</i> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>MAID -</i> | | <i>HOTEL</i> | | <i>Summerton - S. C.</i> | | <i>USA</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>MOSES HILTON</i> | | | | <i>MARY OLIVER</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| <i>NO</i> | | <i>215-12-4990</i> | | <i>JOHN BOATWRIGHT</i> | | <i>2572 Edmondson Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | <i>E. V. A.</i> | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | <i>hypertension & diabetes</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <i>NO</i> | | | | <i>NO</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-26-19-65</i> to <i>1-27-19-65</i> , that (I) (we) last saw the deceased alive on <i>1-27-19-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| <i>S. Siros</i> | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| <i>SIROOS GERAMI</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>1/30/65</i> | | <i>NO CEMETERY</i> | | <i>Baltimore Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| <i>JAN 28 1965</i> | | <i>Robert E. Farley</i> | | <i>Monahan & Sons</i> | | <i>638 N. Gilman St</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

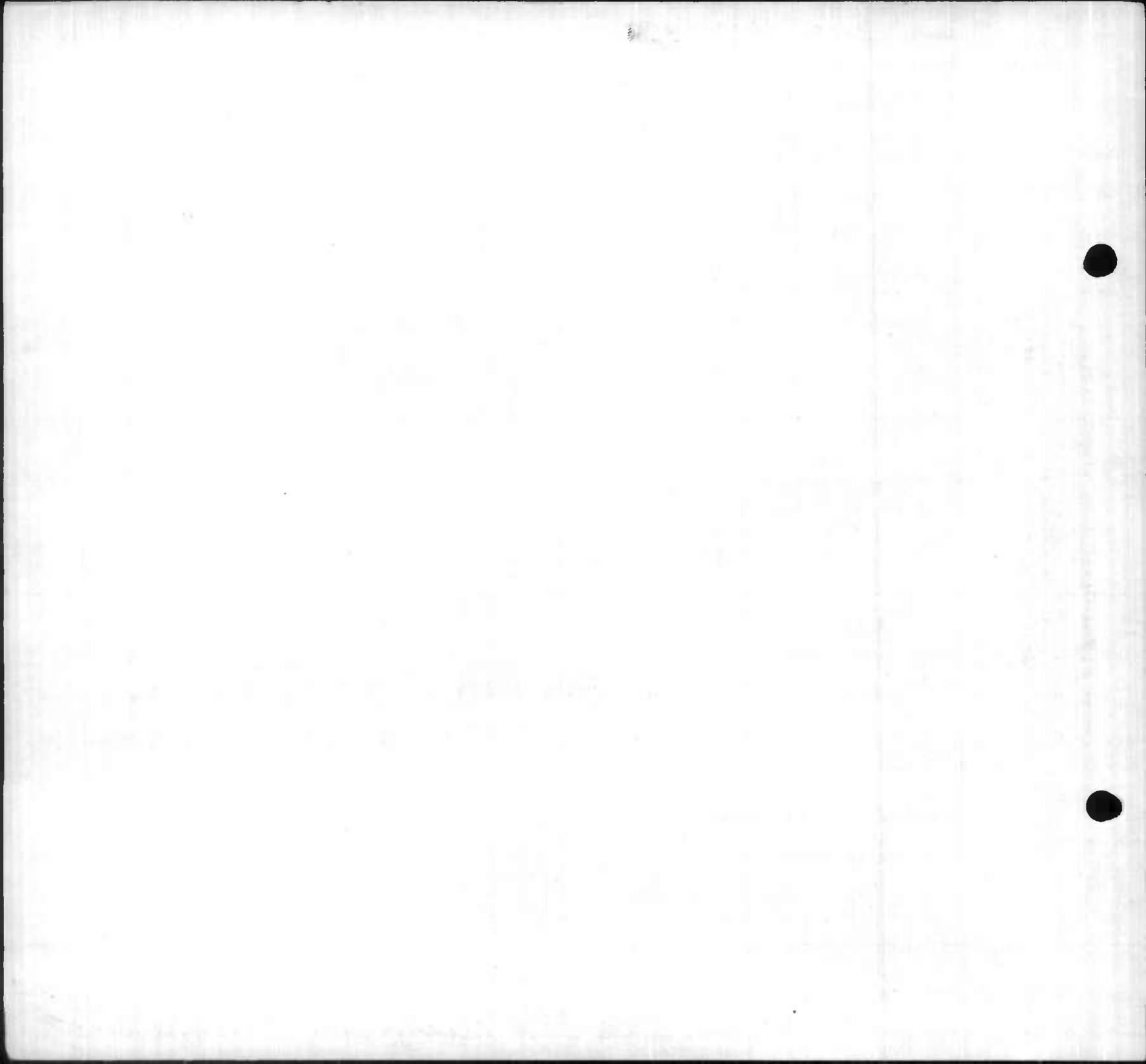
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|---|-------------------------------------|---|--|--|------------------------------------|---|
| BIRTH NO. 65 1010 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 1010 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Hess, Mollie</i> | | | | | 2. DATE AND HOUR OF DEATH <i>1/26/65 12:25 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>27-38</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 12</i> D. STREET ADDRESS (If rural, give location) <i>1608 Wadsworth Way</i> | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never married</i> | | 8. DATE OF BIRTH <i>12/20/88</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> |
| 13. FATHER'S NAME <i>Martin Hess</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Emma ?</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <i>216-01-5748</i> | | 17. INFORMANT <i>Marie L. Pouchat</i> | | |
| 18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <i>Pneumonia</i> (B) <i>Pneumonia</i> (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cerebrovascular accident 1/15/64</i> | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2/2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>2/20</i> 19 <i>64</i> to <i>1/26</i> 19 <i>65</i> , that (I) <u>(we)</u> last saw the deceased alive on <i>1/26</i> 19 <i>65</i> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Robert W. Ireland</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>1/26/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland</i> | | | | | 23D. ADDRESS <i>Montebello State Hosp.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial Jan 30/65 - Most Holy Redeemer Bldg. Md</i> | | 24B. DATE | | | 24C. NAME OF CEMETERY or CREMATORY <i>Most Holy Redeemer Bldg. Md</i> | | 24D. LOCATION (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | | 25C. FUNERAL DIRECTOR <i>W. J. 7.10, 4101 E. ...</i> | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|---|------------------------------------|--|--|--|--|--|-------------------------------|--|--|--|--|
| BIRTH NO. (5) 65 1011 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1011 | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>WERTS, Mrs ANNA A.</u> | | | | | | | | | | 1/27/65 6:00 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived prior to residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL</u> | | | | | | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>16-08</u> | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 29</u> | | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) <u>1001 Wildwood Pky.</u> | | | | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>1-28-06</u> | | 9. AGE (In years last birthday) <u>58</u> | | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>HW</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Joseph HERR</u> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>2620-0881</u> | | | | | 17. INFORMANT <u>Daughter (Mrs Dorothy Carpenter)</u> | | | | | ADDRESS | |
| 18. <u>434.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | CAUSE OF DEATH (A) <u>Congestive heart failure</u> (B) <u></u> (C) <u></u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>65</u> to <u>1-27</u> 19 <u>65</u> . that (I) (we) last saw the deceased alive on <u>1-27</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <u>Too Hyun Sohn</u> | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <u>1-27</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Too Hyun Sohn</u> | | | | | | | | | | M.D. 23D. ADDRESS | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial Jan 30/65</u> | | | | | 24B. DATE | | | | | 24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u> | | | | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u> | | | | | 25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u> | | | | | 25C. FUNERAL DIRECTOR <u>W. H. K. 4101</u> | | | | | ADDRESS <u>Edmondson</u> | |



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G 600

| BIRTH NO. 1565 | | 1012 BALTIMORE CITY HEALTH DEPARTMENT | | 65 1012 | |
|---|-------------------------|--|---|--|---|
| M.E. CASE NO. | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM J. GEARY | | | 2. DATE AND HOUR PRONOUNCED DEAD January 27, 1965 12:05 p. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 700 Fleet St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore CATONSVILLE D. STREET ADDRESS (If rural, give location) 18 Hillside Road 53-00 | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 30, 1907 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | 11. BIRTHPLACE (State or foreign country) md | |
| 13. FATHER'S NAME Wm J. Geary | | | 14. MOTHER'S MAIDEN NAME Catherine Griffin | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 26-01-5570 | | |
| 17. INFORMANT Mrs. Gertrude Geary Wife | | | ADDRESS same | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E975X Drowning INTERVAL BETWEEN ONSET AND DEATH 1 | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | |
| 19A. DATE OF OPERATION 1/27/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Harbor | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Harbor | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) East Falls Avenue | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 27 65 About 11:15a. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Allegedly jumped into harbor | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 23B. DATE Feb. 1/65 | | |
| 23C. NAME OF CEMETERY or CREMATORY New Cathedral | | | 23D. LOCATION (City, town, or county) (State) Balto. 29. Md. | | |
| 24A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | |
| 24C. FUNERAL DIRECTOR W. H. F. L. 4101 Edmonson | | | ADDRESS same | | |

WALTER J. DODGE

PROCESSION

U.S.A.

SECTION

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1013

BIRTH NO. 65 1013

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Emma Lee Dempsey

2. DATE AND HOUR OF DEATH

1-25-65

11:35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

23-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1034 Hanover Street

5. SEX

F

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

4-27-00

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jack Hardy

14. MOTHER'S MAIDEN NAME

Alice -

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Chart

ADDRESS

18. 440X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Arteriosclerotic Nephrosclerosis

Years

(B) Chronic Glomerulonephritis

Years

(C) Chronic Renal Failure with Uremia

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Not While
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 1-20 1965 to 1-25 1965,
that ~~the~~ (we) last saw the deceased alive on 1-25 1965 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~We~~ (We) (did) (did not) view the body after death.

23A. SIGNATURE

D. Bernard Pleet, M.D.

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

1-25-65

23C. PHYSICIAN'S
NAME (Type)

A. Bernard Pleet

23D. ADDRESS

M.D. University Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1965

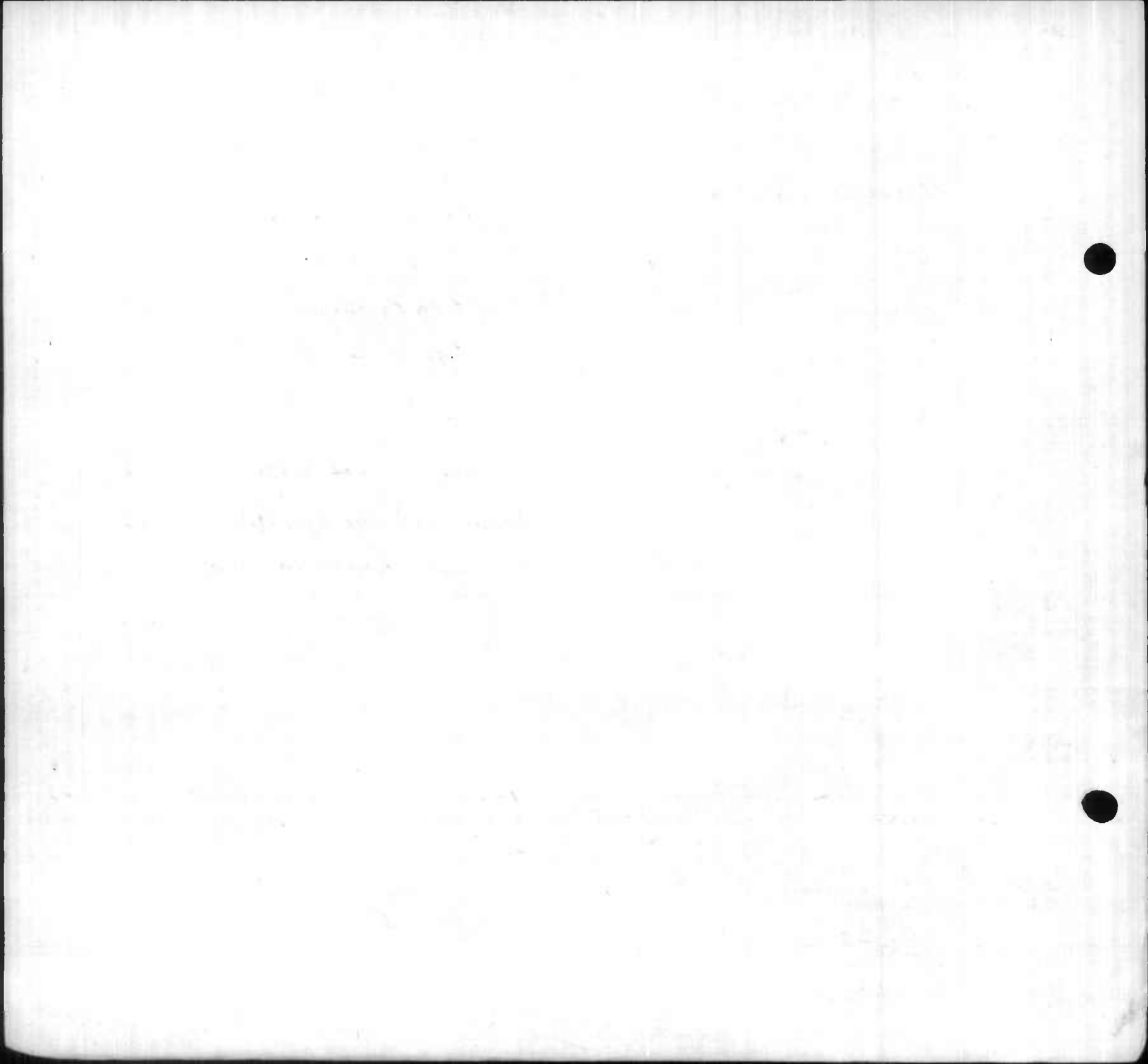
25B. NAME of REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

J. P. Rountree, 10840 Montgomery H

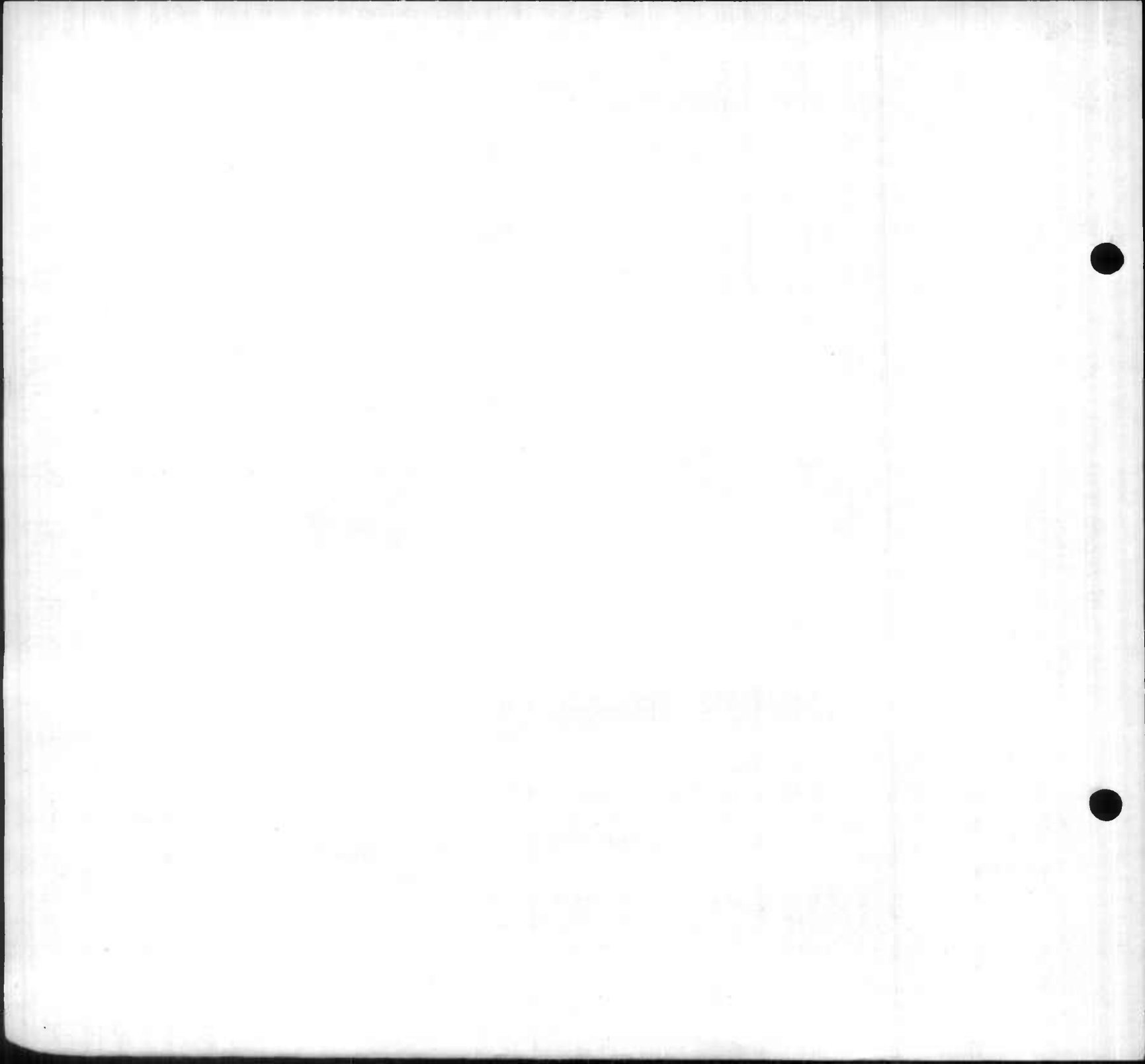
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--------------------------|---|-------------------------------------|--|--|
| 65 1014 | | CERTIFICATE OF DEATH | | 65 1014 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>John Armstrong, William</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>1/25/65 7AM</i> | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2301</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hosp</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt. Md</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>915 Leadenhall St</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Caucas</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>12/11/01</i> | 9. AGE (In years last birthday) <i>63</i> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Arch</i> | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>William Armstrong</i> | | 14. MOTHER'S MAIDEN NAME <i>Lou Furnish</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Evelyn Wheeler 915 Leadenhall St</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>150X + 1E 95 1.9</i> | | CAUSE OF DEATH (A) DUE TO <i>Carcinoma of the Esophagus</i> (B) DUE TO <i>Serum Hepatitis</i> (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>~1 wch</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION <i>0</i> | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/19</i> 19 <i>65</i> to <i>1/25</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>730pm 1/25</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Henry J. Spivak</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>1/25/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>T. C. SPIVAK</i> | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/30/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Ct</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Balt City</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | |
| 25C. FUNERAL DIRECTOR <i>J. J. Brown</i> | | 25D. ADDRESS <i>108 W. Montgomery St</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

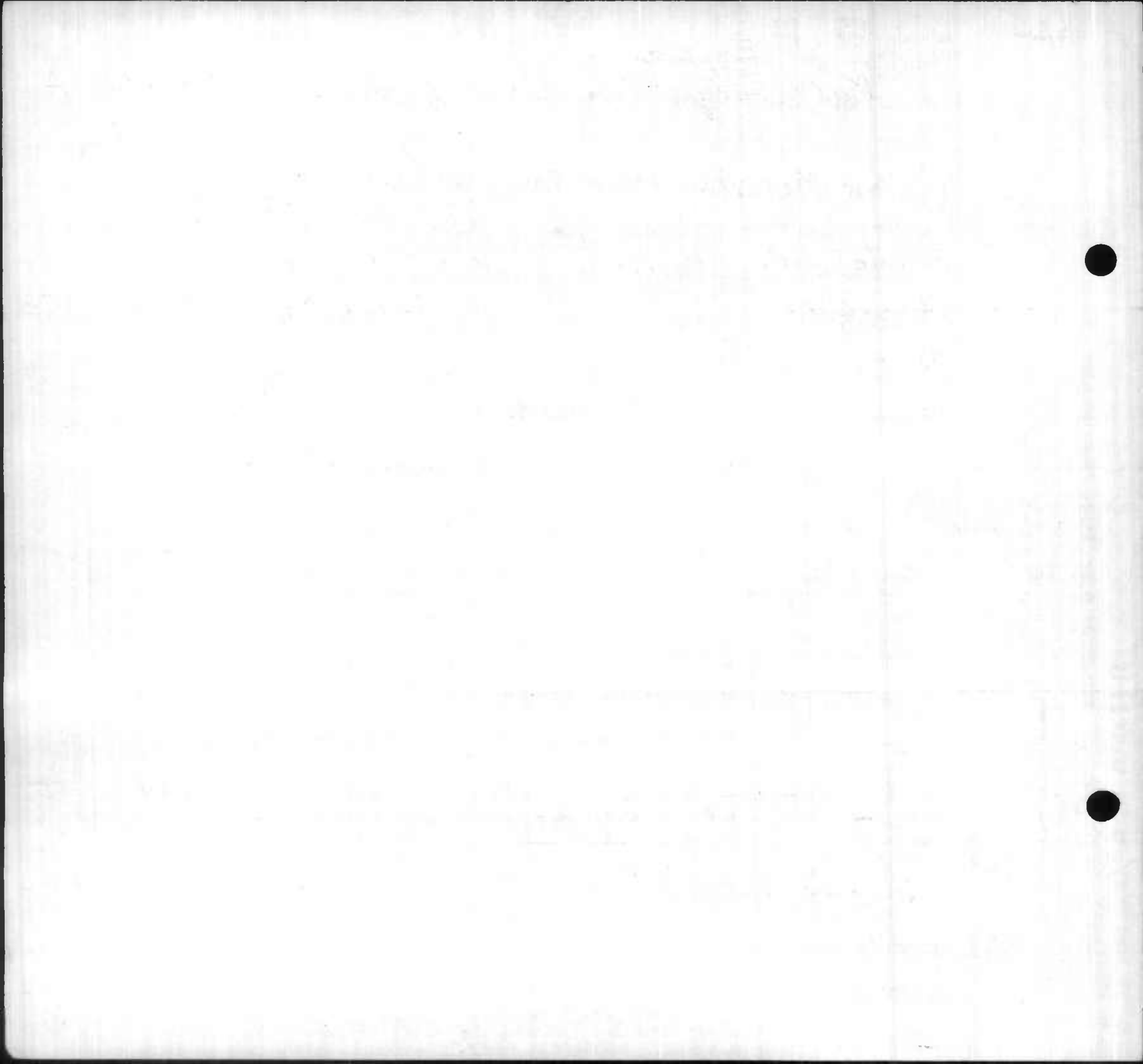
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---|--|--|---|---|---|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1015 | | | | | |
| BIRTH NO. 65 1015 | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) William CLARENCE ROBINSON | | | | | 2. DATE AND HOUR OF DEATH 1-24-65 4:10 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL | | | | | A. STATE MARYLAND, SAINT MARY'S | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) PINEY POINT 68-00 | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED | | 8. DATE OF BIRTH 12-3-09 | 9. AGE (In years last birthday) 52 | 11. Under 1 Yr. Months: Days: Hours: Min. | | 12. Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Piney Point, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PERRY ROBINSON | | | | | 14. MOTHER'S MAIDEN NAME IDA GROSS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs Helen E. Thompson Piney Point, Maryland | | | | |
| 18. 20431 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | CAUSE OF DEATH (A) Acute Leukemia DUE TO (B) Anemia Thrombocytopenia DUE TO 2040 A) (C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months 1 month |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Pulmonary infiltrate? AFB ? | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/22 19 <u>65</u> to 1/24 19 <u>65</u> , that (I) (we) last saw the deceased alive on 4/10/24 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Jenny J. Spivak | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1/24/65 | | |
| 23C. PHYSICIAN'S NAME (Type) J.L. SPIVAK | | | | | 23D. ADDRESS M.D. JOHNS HOPKINS Hospital, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/65 | | 24C. NAME of CEMETERY or CREMATORY St. Marks Cemetery | | | 24D. LOCATION (City, town, or county) (State) Valley Lee, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland | | | | | |

By

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

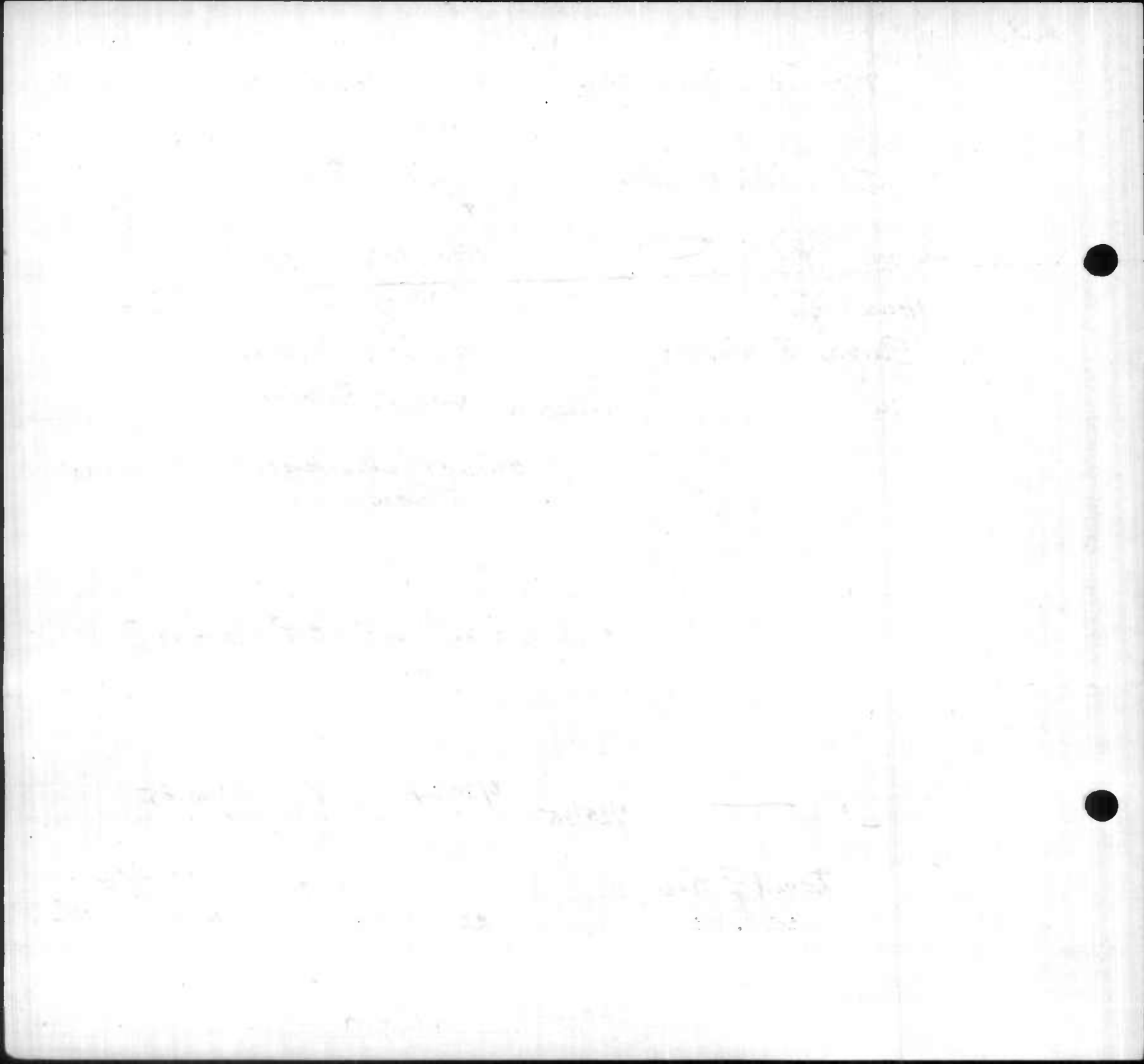
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. 65 1016 | | CERTIFICATE OF DEATH | | 65 1016 | |
| M.E. CASE NO. Emma | | | | | |
| 1. NAME OF DECEASED (Type or Print) Mary Elizabeth Adelone | | | 2. DATE AND HOUR OF DEATH Jan. 24 1965 9:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | | A. STATE Maryland B. COUNTY 9-031 | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 18 | | |
| | | | D. STREET ADDRESS (If rural, give location) 627 E. 37th St. | | |
| 5. SEX Female | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-21-96 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | 13. FATHER'S NAME Joe Smith | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-12-8411 | | 17. INFORMANT Ruth DePasquale ADDRESS 2707 Alameda | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarct ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary atherosclerosis | | | CAUSE OF DEATH (A) Acute myocardial infarct DUE TO (B) Coronary atherosclerosis DUE TO (C) | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19, 1965 to Jan. 24 1965 , that (I) (we) last saw the deceased alive on Jan. 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles S. Fletcher M.D. | | | | 23B. DATE SIGNED Jan 24, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 1-28-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Balto, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR John P. Mueller Jr. | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

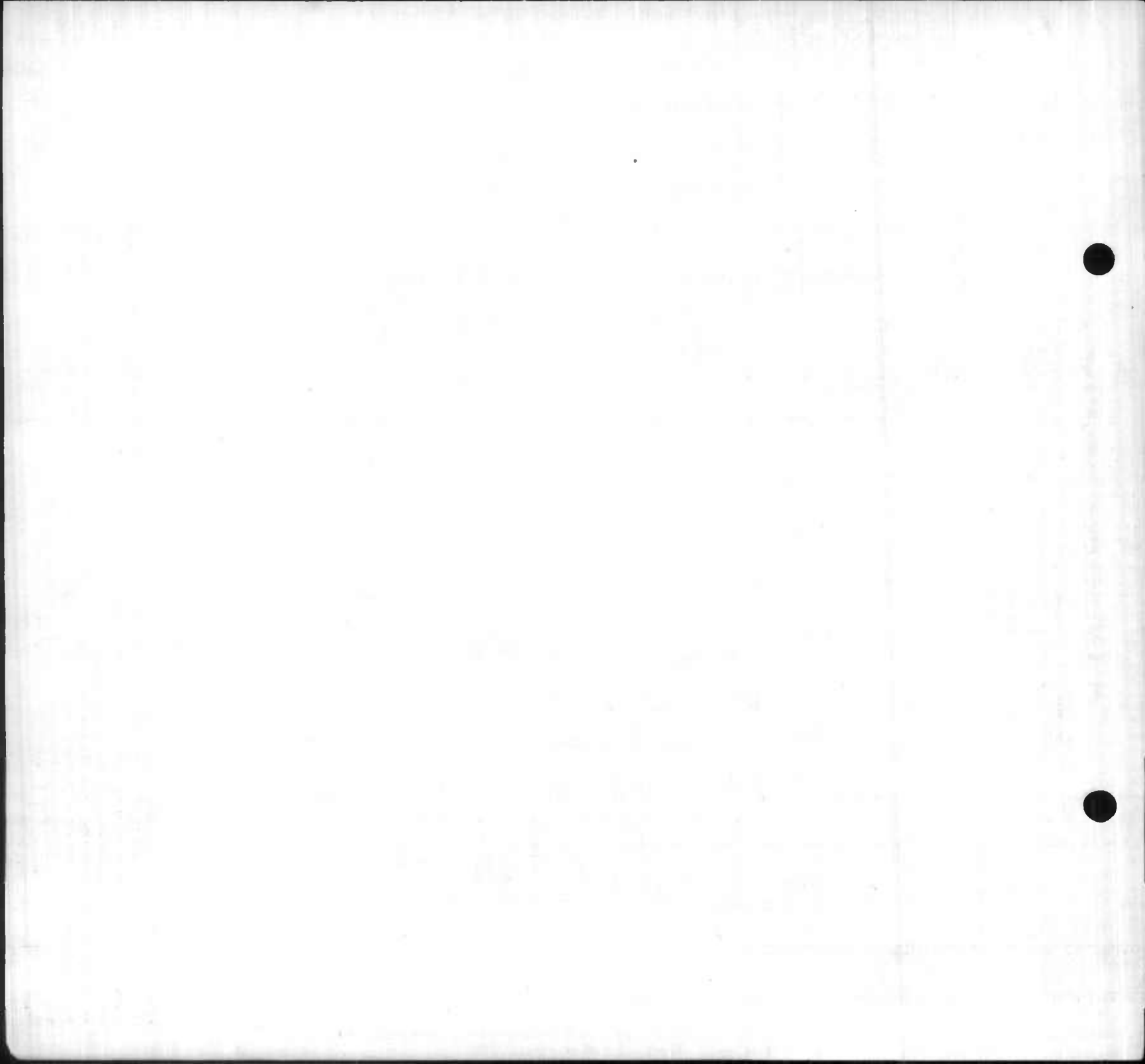
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|-----------------------------------|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1017</u> | | | | |
| BIRTH NO. <u>65 1017</u> | | | | | | | | | |
| M.E. CASE NO. <u>65 1017</u> | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Morris, Anna Mae</u> | | | | | 2. DATE AND HOUR OF DEATH <u>Jan. 25, 1965</u> <u>5:15 a.</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hospital</u> | | | | | A. STATE <u>Maryland</u> | | | | |
| | | | | | B. COUNTY <u>Harford</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, give RURAL and give township) <u>White Ford</u> <u>62-00</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>7</u> | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH <u>9/30/1903</u> | | 9. AGE (In years last birthday) <u>61</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>George Penkton</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Marlan Parker</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT ADDRESS <u>Hospital Records.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerotic heart disease</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> | | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| 18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>cerebral thrombosis & rt. hemiparesis 2 yrs.</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/30/64</u> 19 to <u>1/25/65</u> 19, that (I) (we) last saw the deceased alive on <u>1/25/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Daniel G. Lai</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>1/25/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Daniel G. Lai</u> | | | | | 23D. ADDRESS M.D. <u>2201 Argonne Drive, Baltimore, Md</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-28-1965</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Slate Ridge</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Delta, Penna.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>John H. Harkins</u> | | | ADDRESS <u>Delta, Penna.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

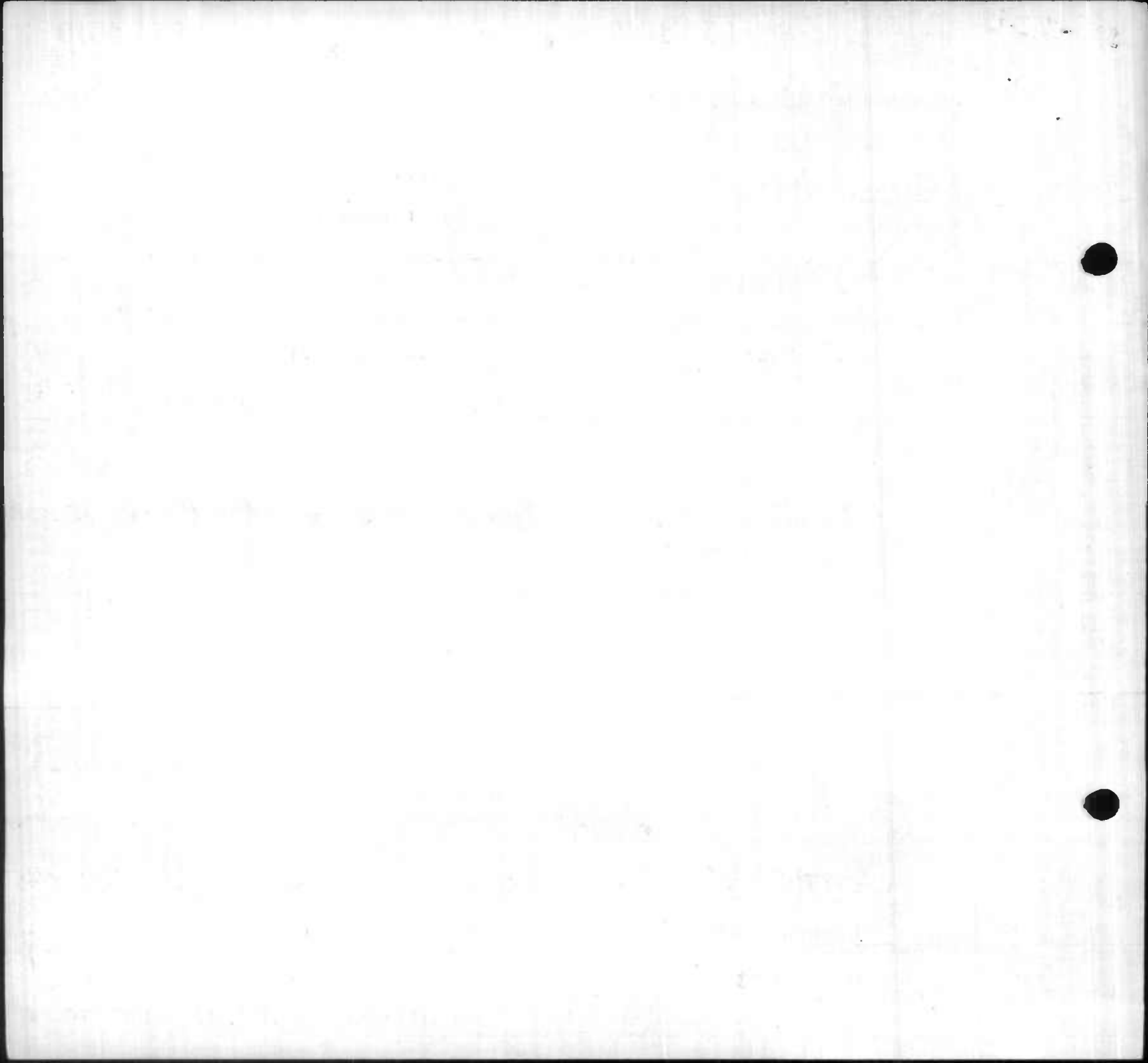
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1018 | |
|---|---------------------|---|---|--|--|
| BIRTH NO. 65 1018 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Sister Noemi de ST. Agnes Viel</i> | | | 2. DATE AND HOUR OF DEATH <i>1-26-65 3:15 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>16-01</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Little Sisters of The Poor 1200 Valley St., Baltimore, Md. 21202</i> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>1200 Valley St.</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>3-4-1874</i> | 9. AGE (In years last birthday) <i>90</i> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious</i> | | | 11. BIRTHPLACE (State or foreign country) <i>FRANCE</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>FRANCE</i> |
| 13. FATHER'S NAME <i>Cheophile Viel</i> | | | 14. MOTHER'S MAIDEN NAME <i>Perrine Brilhout</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <i>Little Sisters of the Poor 1200 Valley St.,</i> | | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary edema</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Chronic O.S.C.V.D.</i> <i>Sensitivity</i> | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 24</i> to <i>Jan 26</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Jan 26</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Stanley Ankudas</i> M.D. | | | | 23B. DATE SIGNED <i>1-27-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. Stanley Ankudas</i> | | | 23D. ADDRESS M.D. <i>1802 W. Baltimore St.,</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/29/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Cathedral</i> | |
| | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Philip Herwig Sons Orleans et</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|-------------------------|--|---|------------------------------------|---|--|--|--|--|---|
| PENNSYLVANIA 65 1019 | | | | | REGISTERED NO. 65 1019 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Kalik, Jolie Beth</i> | | | | | 2. DATE AND HOUR OF DEATH <i>1/27/65 9 a.m.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>NEW JERSEY</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>LEVITTOWN</i> D. STREET ADDRESS (If rural, give location) <i>48 HILLCREST LANE</i> | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>CHILD</i> | | 8. DATE OF BIRTH <i>6-12-63</i> | 9. AGE (In years last birthday) <i>1</i> | If Under 1 Yr. Months: <i>7</i> Days: <i>15</i> | | If Under 24 Hrs. Hours: <i></i> Min. <i></i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>HARVEY KALIK</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>BARBARA BENNETT</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>MR. HARVEY KALIK 48 HILLCREST LANE WILLINGBORO, N. J.</i> | | | |
| 18. <i>734.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cyanotic Congenital Heart Disease 18 months</i> | | | | | CAUSE OF DEATH (A) <i>Pneumonia</i> DUE TO (B) <i>Cyanotic Congenital Heart Disease</i> DUE TO (C) <i></i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>January 26 1965</i> to <i>January 27 1965</i> , that (I) (we) last saw the deceased alive on <i>Jan. January 27 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Lenora Regan</i> M.D. | | | | | | | 23B. DATE SIGNED <i>Jan 27, 1965</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>LENORA REGAN</i> | | | | | | | 23D. ADDRESS M.D. <i>THE JOHNS HOPKINS HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | | | 24B. DATE <i>1/28/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>BETH MOSES</i> | | 24D. LOCATION (City, town, or county) (State) <i>PINELAWN LONG ISLAND, NEW JERSEY</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | | 25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</i> | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1020

BIRTH NO. 65 1020

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

NANCY T. HENDERSON

2. DATE AND HOUR OF DEATH

1/27/65

11:15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

PROVIDENT HOSPITAL

BALTO. 17, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

BALTO. MD

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO. MD.

D. STREET ADDRESS (If rural, give location)

2507 CHELSEA TERRACE

5. SEX

Female

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
WIDOWED

8. DATE OF BIRTH

11/25/86

9. AGE (In years
last birthday)

78

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Teacher

10B. KIND OF BUSINESS OR INDUSTRY

Public School

11. BIRTHPLACE (State or foreign country)

N.C. Statesville

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

HENRY TURNER

14. MOTHER'S MAIDEN NAME

Ellen Johnson

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

213-14-0429

17. INFORMANT

ANN REED 2507 CHELSEA TERRACE

ADDRESS

NEECE

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

TERMINAL

INTERVAL BETWEEN
ONSET AND DEATH

2 days

(A) DUE TO

BRONCHOPNEUMONIA

(B) DUE TO

THROMBOSIS
PROGRESSIVE CEREBRAL

5 wks

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

ARTERIAL NEPHROSCLEROSIS

UNKNOWN

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 26 1964 to Jan 27 1965,
that (I) (we) last saw the deceased alive on Jan 27 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Roland T. Smoot, M.D.

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1/27/65

23C. PHYSICIAN'S
NAME (Type)

ROLAND T. SMOOT

M.D.

23D. ADDRESS

3517 Copley Rd., BALTO. 15, MD

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/30/65

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1965

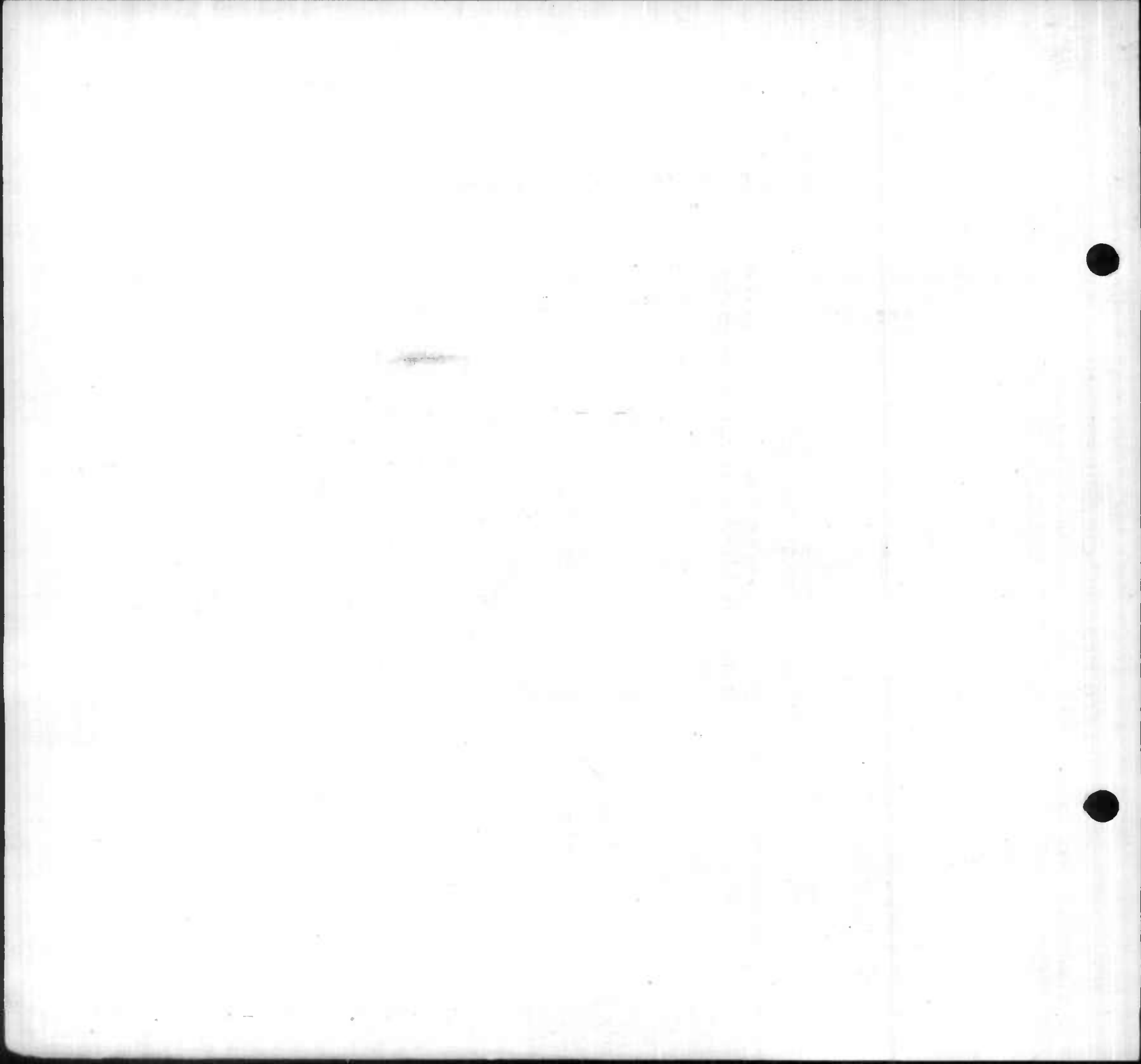
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

ADDRESS



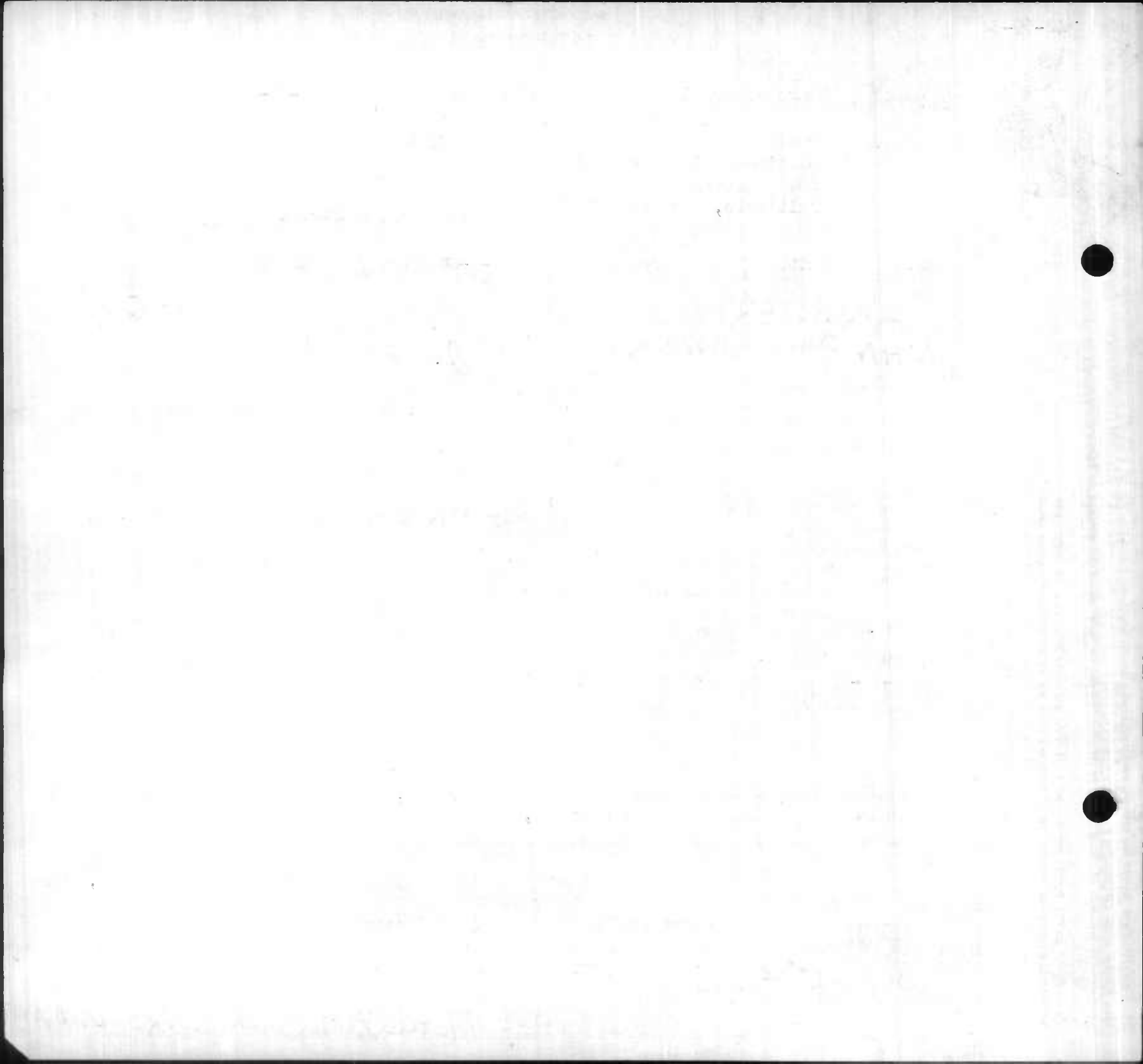
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31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 65 1021 | |
| 1. NAME OF DECEASED (Type or Print) APPROWSKI HENRY | | 2. DATE AND HOUR OF DEATH 1-21-65 7:30 a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-09 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 3722 Hudson Street | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3-1-1884 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Poland | |
| 13. FATHER'S NAME JOHN ZAPOROWSKI | | 14. MOTHER'S MAIDEN NAME JOSEPHINE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 21305 5351 | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. 434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Renal Failure | | CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) Congestive Heart Failure DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years 2 weeks | |
| 19A. DATE OF OPERATION 1-20-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Amputation of Left foot | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from January 12, 1965 to January 21, 1965 , that (I) (we) last saw the deceased alive on January 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert Cooke | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED January 21, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Robert Cooke | | M.D. 23D. ADDRESS 4940 Eastern Avenue 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-23-65 | | 24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM | |
| 24D. LOCATION (City, town, or county) (State) 6575 BOSTON ST. MD | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965 | | 25B. NAME OF REGISTRAR Marie Fialkowski | |
| 25C. FUNERAL DIRECTOR 1000 ADDRESS | | 25D. ADDRESS S. KENWOOD AVE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1022 | |
|---|------------------|--|---------------------------------|--|--|
| BIRTH NO. 65 1022 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Bishop JEANNE I | | | |
| 2. DATE AND HOUR OF DEATH 9 AM 1-28-65 | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | A. STATE Md. B. COUNTY Baltimore | | | |
| C. CITY OR TOWN Randallstown | | If outside city limits, write RURAL and give township 33-00 | | | |
| D. STREET ADDRESS 9124 Bengal Rd | | E. ZIP CODE 21133 | | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH May 6, 1921 | 9. AGE (In years last birthday) 45 years | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY A. & P. Food | | 11. BIRTHPLACE (State or foreign country) Killingly, Conn. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Rose | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. 041-18-9462 | | 17. INFORMANT Mr. Charles A. Bishop 9124 Bengal Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cardiac embolism (B) DUE TO Ruptured aortic aneurysm (C) DUE TO bleeding | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-17-1965 to 1-28-1965, that (I) (we) last saw the deceased alive on 1-28-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. G. G. M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) SIROOS GERAMI M.D. | | | | 23D. ADDRESS Lutheran Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION Baltimore, Md. | | 24E. CITY, TOWN, or COUNTY | | 24F. STATE | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Joseph Byrnes 8728 Liberty Rd. Randallstown | |

1. The first of these is the fact that the
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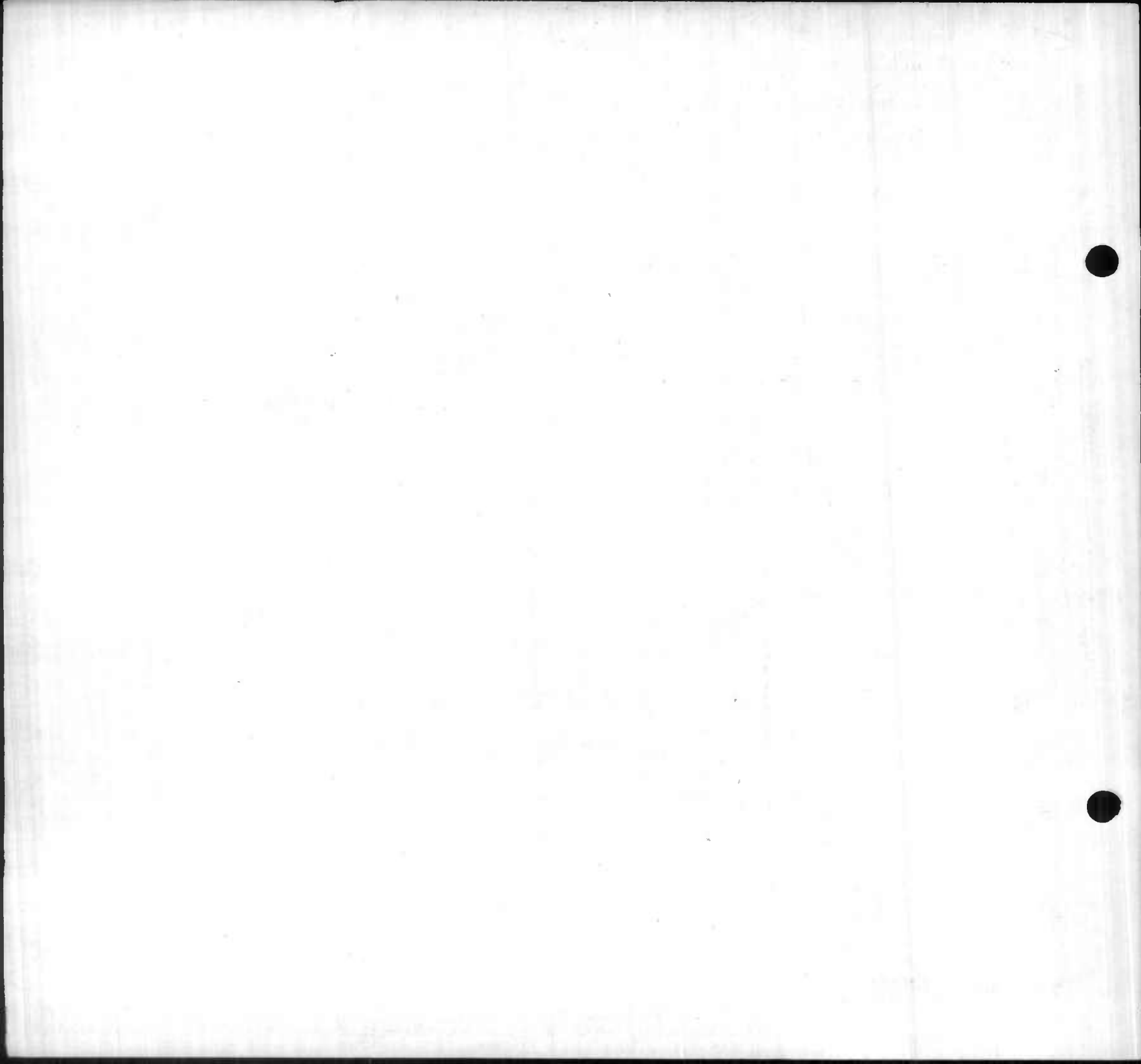
the first of these is the fact that the

the first of these is the fact that the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

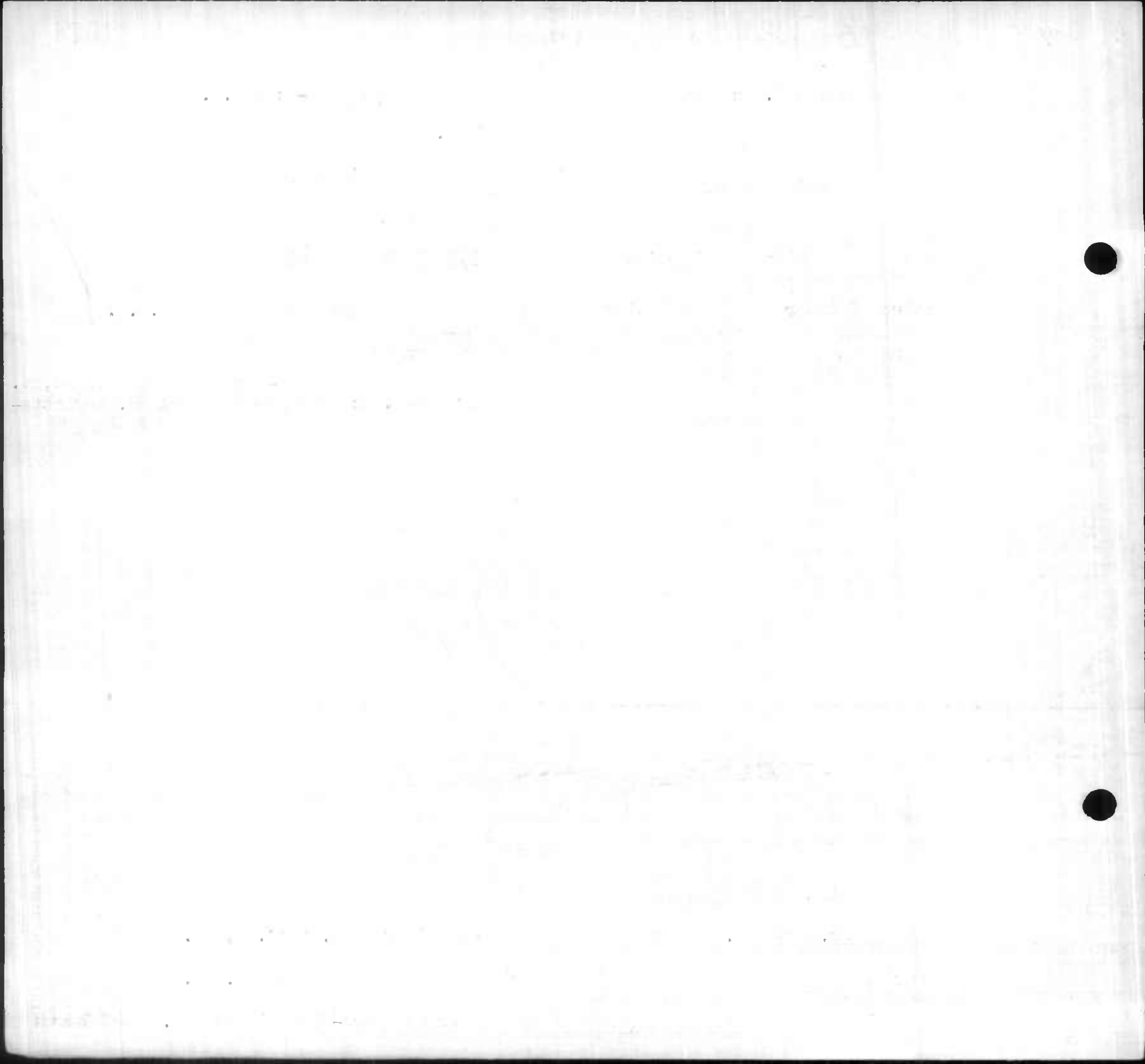
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1023 | |
|---|--|--|--|--|--|---|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | BARBARA M. CISA R | | Jan. 28, 1965 | | 1230 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1413 Church St. | | | | A. STATE Md. | | | |
| | | | | B. COUNTY 2505 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto City | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1413 Church St Zone 26 | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH Oct. 20, 1879 | 9. AGE (In years last birthday) 85 | 10. CITIZEN OF WHAT COUNTRY? Czechoslovakia | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Czechoslovakia | |
| 13. FATHER'S NAME Charles Vaclav Hedja | | | | 14. MOTHER'S MAIDEN NAME Marie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Mrs. Rose Bradshaw | |
| | | | | ADDRESS 1413 Church | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Arteriosclerotic Heart Disease DUE TO disease (B) Coronary Heart Disease DUE TO Marked cerebral sclerosis (C) Marked cerebral sclerosis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Marked mental Retardation | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 19 19 64 to Jan 28 19 65 , that (I) (we) last saw the deceased alive on 1/19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Samuel Rubin | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) Samuel Rubin, | | | | 23D. ADDRESS 203 Patapsco Avenue Baltimore, Md. 21225 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross | | 24D. LOCATION (City, town, or county) (State) A.A. Co. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Wm. S. Fialkowski | | ADDRESS 2007 Eastern Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

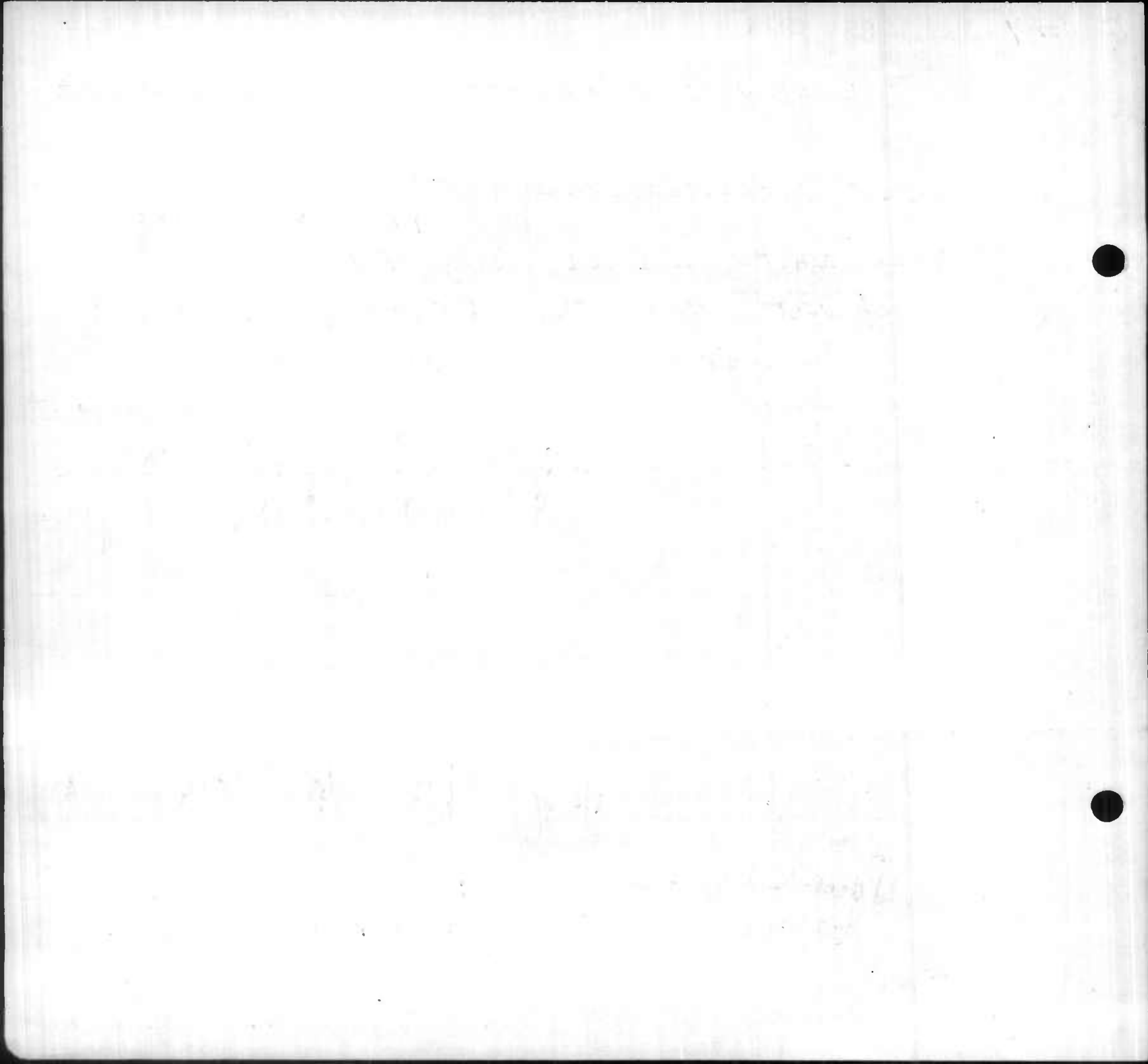
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1024 | | | | |
| BIRTH NO. 65 1024 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) Robert S. McLaren | | | | | 2. DATE AND HOUR OF DEATH 1/26/65 - 2:45 p.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Marriottsville 21104 D. STREET ADDRESS (If rural, give location) Box 82A | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11/17/1882 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter | | | 10B. KIND OF BUSINESS OR INDUSTRY Painting | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Unknown | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ernest H. McLaren Wards Chapel Rd. Marriottsville, Md. | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction - 10 yrs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD - | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| 19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1961 to 1/26 1965 , that (I) (we) last saw the deceased alive on 1/25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Dr. Morton J. Ellin | | | | | 23B. DATE SIGNED 1/27/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Morton J. Ellin | | | | | 23D. ADDRESS 8629 Liberty Rd. Balt. 7, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY Lake View Memorial | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

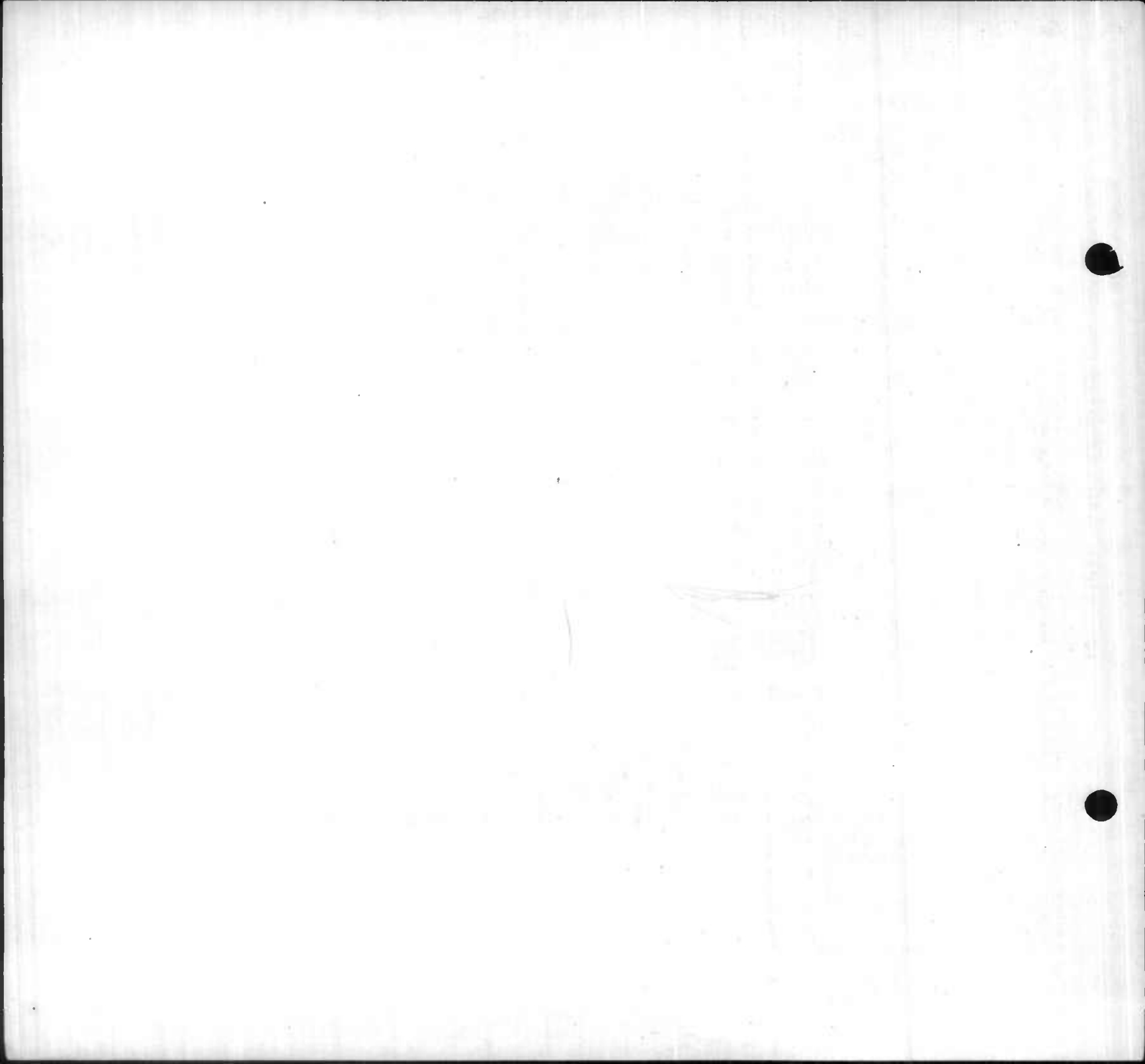
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1025</u> | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. <u>65 1025</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>GUSTAV C. MINZLAFF</u> | | 2. DATE AND HOUR OF DEATH <u>JAN. 26, 1965 3:30 A. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>HOUSE IN THE PINES</u> <u>2525 W. BELVEDERE AVE</u> | | A. STATE <u>MARYLAND.</u> B. COUNTY <u>25-33</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2349 Sidney AVE</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u> | 8. DATE OF BIRTH <u>July 2, 1887</u> | 9. AGE (In years last birthday) <u>77</u> | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAchineist</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop.</u> | | 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>212-01-9020</u> | 17. INFORMANT ADDRESS <u>Theodor HELLEISEN 329 W. Madison St.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>527.1 I</u> | | CAUSE OF DEATH (A) DUE TO <u>Pulmonary Embolism</u> (B) DUE TO <u>Coronary Artery Disease</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> <u>1965</u> to <u>1/26</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Paul Schonfeld</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>1/27/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Paul Schonfeld</u> | | 23D. ADDRESS M.O. <u>2301 Annapolis Rd Baltimore 30 Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-30-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MT. OLIVET</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Geo. L. Schwaab Funeral Home</u> <u>Francis W. Miller 2101 Franklin Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1026</u> | |
|--|-------------------------|--|--------------------------------------|--|--|
| BIRTH NO. <u>65 1026</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mary K. Stober</u> | | 2. DATE AND HOUR OF DEATH <u>1/26/65</u> <u>11 25</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>26-01</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>5411 Mayview - Ave</u> | | D. STREET ADDRESS (If rural, give location) <u>5411 Mayview - Ave</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>✓</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>11/3/1886</u> | 9. AGE (In years last birthday) <u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u> | |
| 13. FATHER'S NAME <u>? Kikas</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u> | |
| 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mrs. D. Emma Horant</u> | | ADDRESS <u>Above</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Lymphosarcoma</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-4-</u> 19 <u>63</u> to <u>1-26</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-19-</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Juri Hinnu</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>1-28-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Juri Hinnu</u> | | 23D. ADDRESS M.D. <u>5002 Frankford Avenue Baltimore Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/30/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cem.</u> | |
| 24D. LOCATION <u>Woodlawn Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>John J. Cowan & Son Inc</u> | | ADDRESS <u>23.2nd St.</u> | | | |



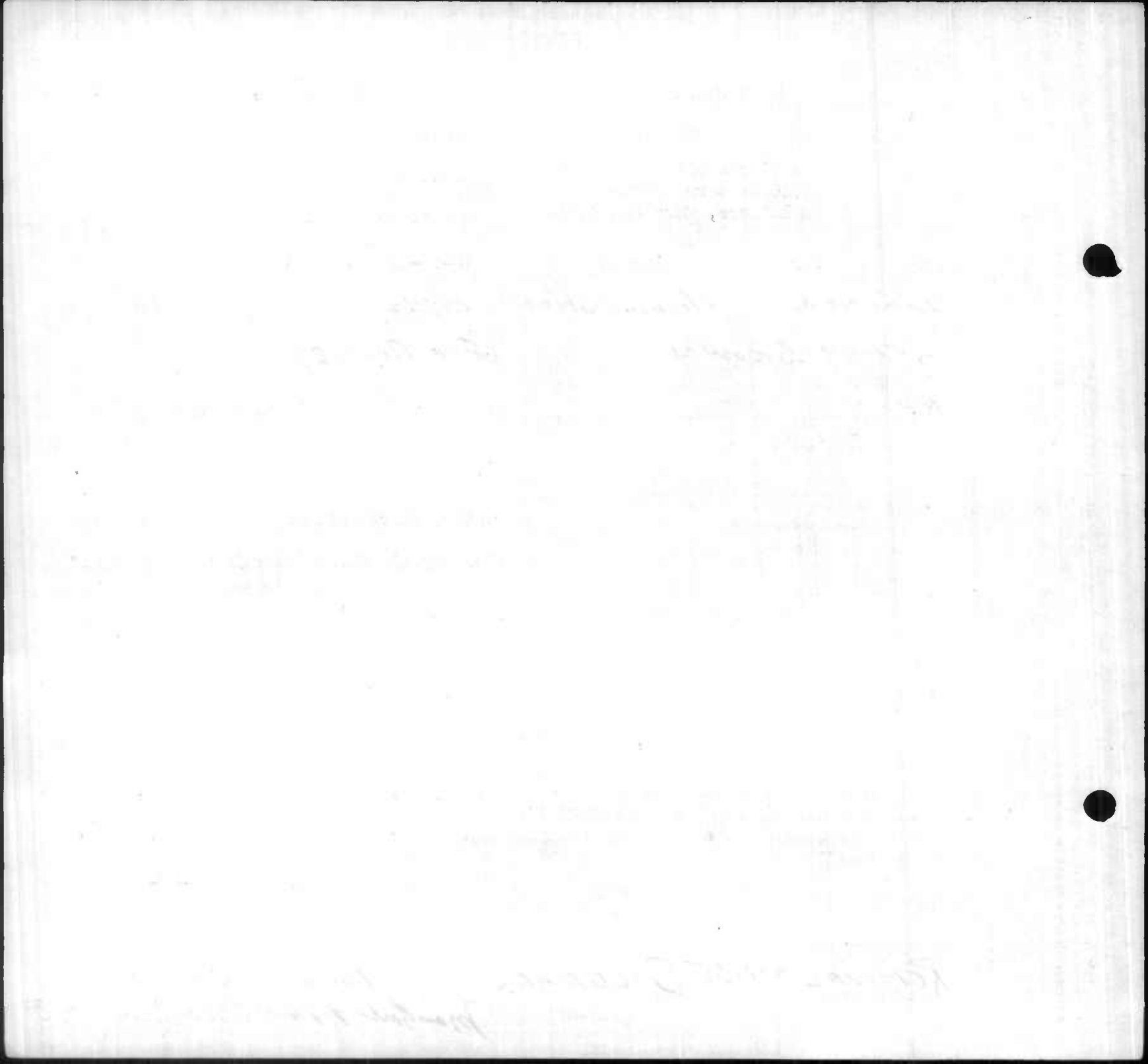
cdg: 39-31-57

31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1027 | |
|--|--|---|--|-------------------------------------|--|
| BIRTH NO. 65 1027 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 2. DATE AND HOUR OF DEATH | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland | | January 27, 1965 4:30 P.M. | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | | |
| Baltimore | | 8 West York Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | Negro | Widowed | 12-16-93 | 71 | Lawyer |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Lawyer | | Clothing Store | Virginia | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Henry Brown | | | Fur Grigsby | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| NO | | | RECORDS: BCH 4940 Eastern Avenue 21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | (A) Cardiac Arrhythmia | | 45 min. | |
| ANTECEDENT CAUSES | | (B) Congestive Heart Failure | | 4 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Arteriosclerotic Cardio Vascular Disease | | years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Acidosis | | 2 days | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19, 1965 to January 27, 1965, that (I) (we) last saw the deceased alive on January 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| Julius Krevans | | | | | 1-27-65 |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| Julius Krevans M.D. | | | 4940 Eastern Avenue | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Removal | 2-1-65 | GOLDMAN'S | ALEXANDRIA VA | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 29 1965 | Robert E. Taylor, M.D. | Mansel P. Hays 638 N. GILMAN ST | | | |



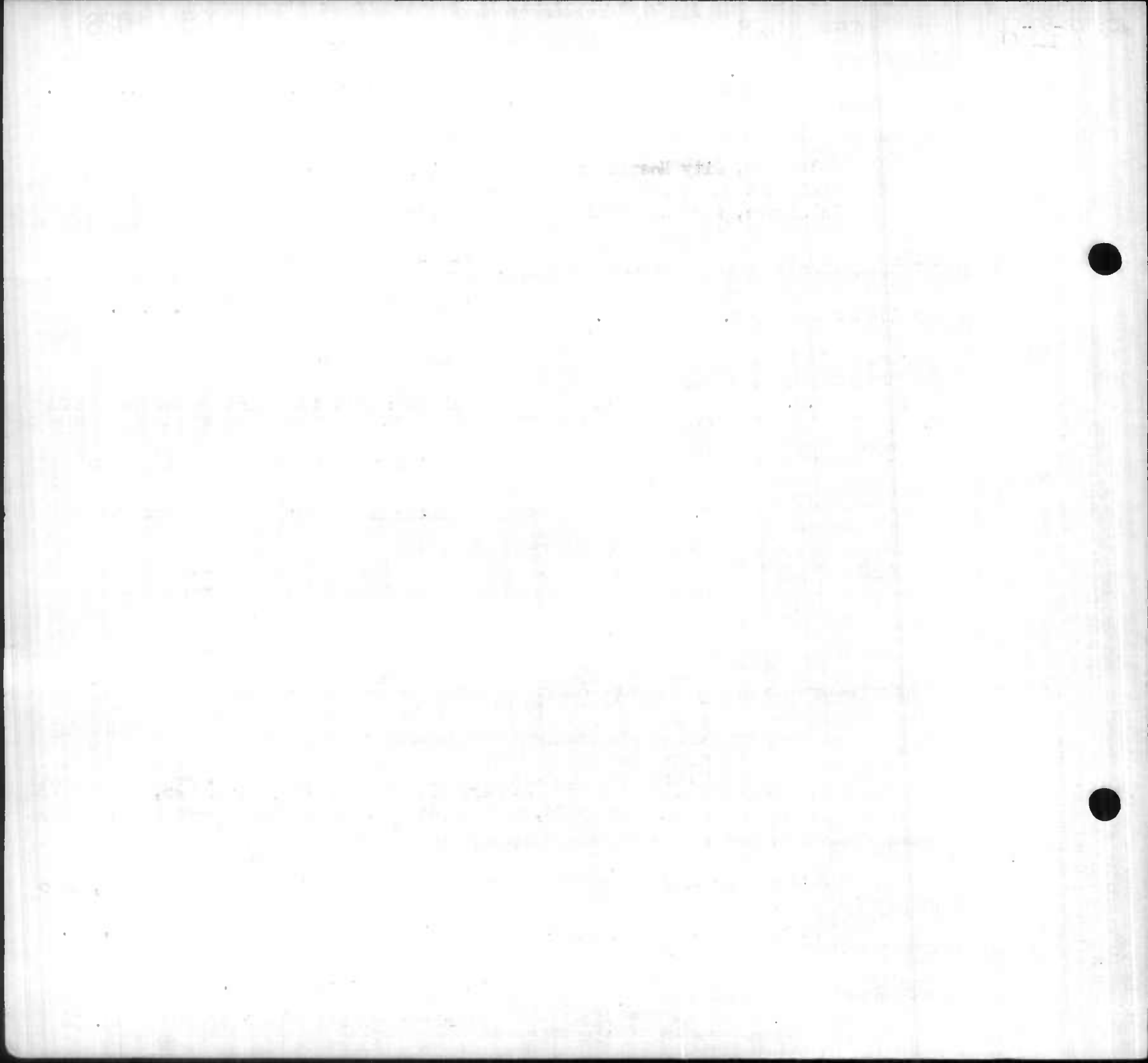
LS: 42-69-51

31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

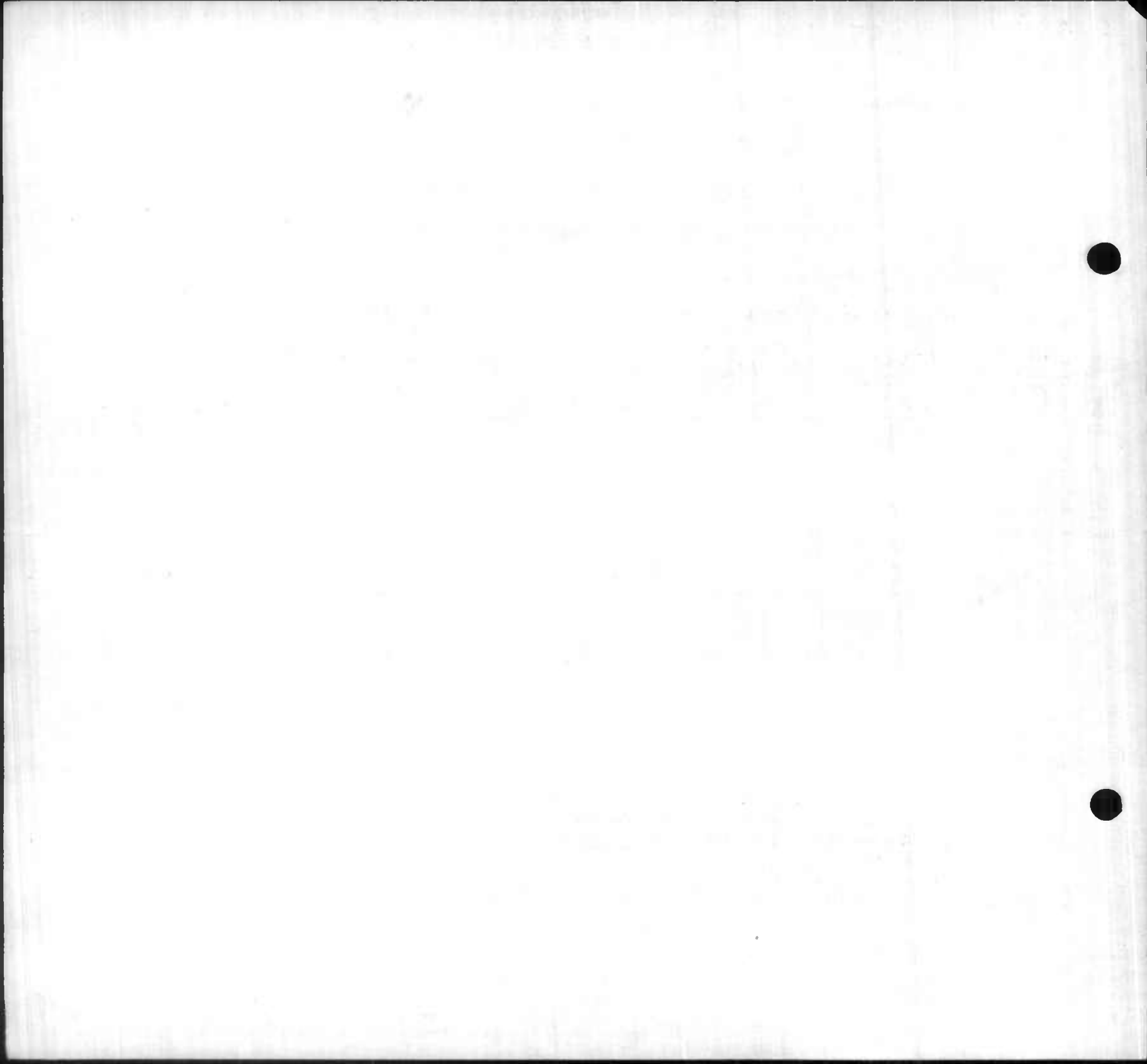
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1028 | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. 65 1028 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) L. John Laubach | | | | January 25, 1965 10:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore, City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY Baltimore | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL: Bradshaw | |
| | | | | D. STREET ADDRESS (If rural, give location) Jerrico Road | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2-10-28 | 9. AGE (In years last birthday) 36 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Oper. | | | 10B. KIND OF BUSINESS OR INDUSTRY Self Emp. | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Christian Laubach | | |
| 14. MOTHER'S MAIDEN NAME Catherine Graver | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.#2 | | |
| 16. SOCIAL SECURITY NO. 217-24-3091 | | | 17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident | | | | INTERVAL BETWEEN ONSET AND DEATH 6 1/2 Hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Probable Aneurysm (Berry) | |
| | | | | (B) DUE TO Unknown | |
| | | | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 25, 1965 to January 25, 1965 , that (I) (we) last saw the deceased alive on January 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Julius Krevans M.D. | | | | 23B. DATE SIGNED January 25, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Julius Krevans M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue #21224 Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE I/29/65 | | 24C. NAME of CEMETERY or CREMATORY Garden of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd. 36 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

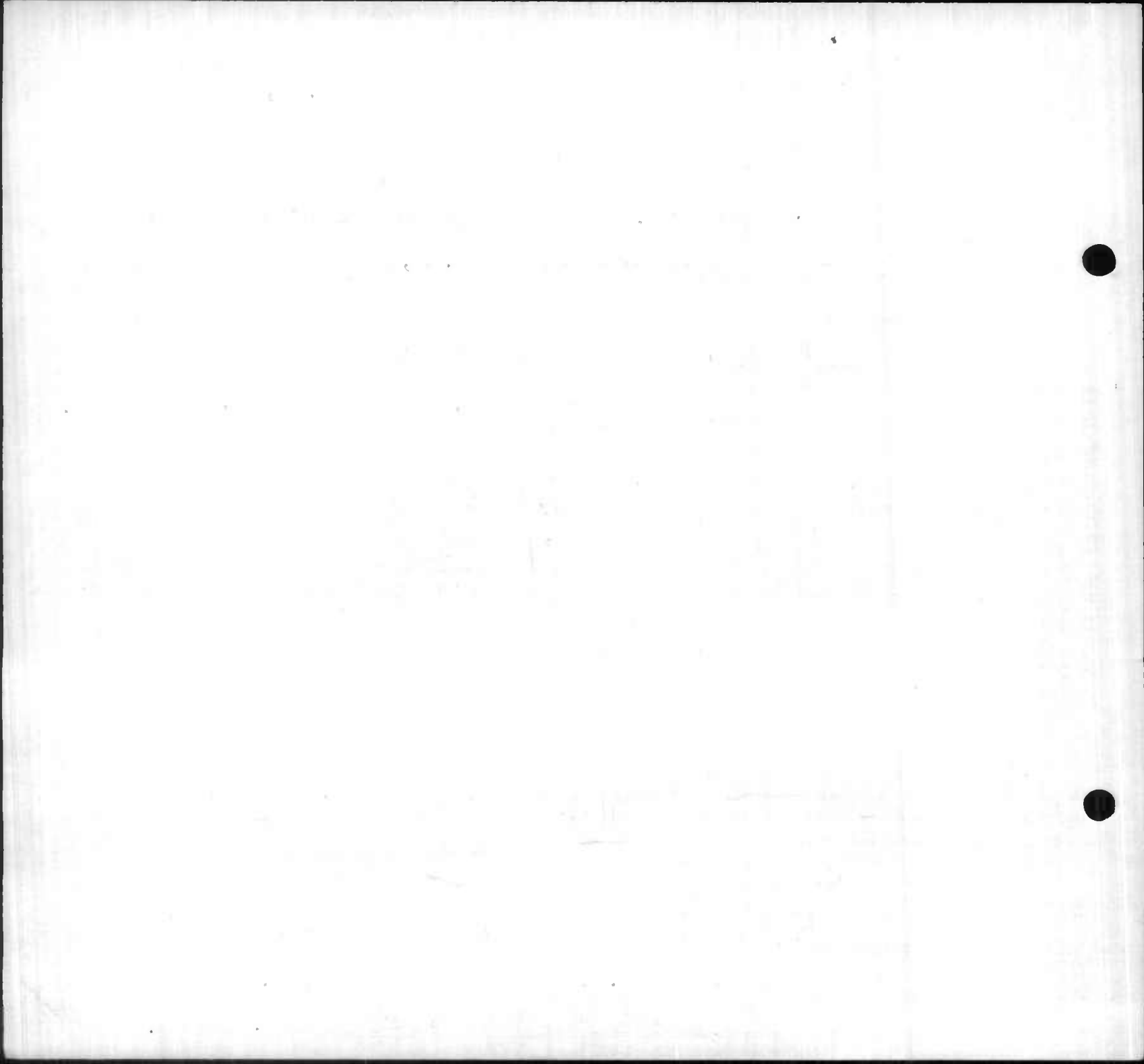
| BIRTH NO. 65 1029 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED No. 65 1029 | |
|--|---------------------|---|---|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ZEPP, ALBERT EDWARD | | | | 2. DATE AND HOUR OF DEATH JAN. 25, 1965 10 45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 53-00 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Granite, Md. | | | |
| | | | | D. STREET ADDRESS (If rural, give location) Herwood Rd (P.O. Woodstock Md) | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/17/91 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monument Dealer | | | 10B. KIND OF BUSINESS OR INDUSTRY Stone | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
| 13. FATHER'S NAME George Zepp | | | | 14. MOTHER'S MAIDEN NAME Emma Albright | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-07-1780 | | 17. INFORMANT Wife | | ADDRESS same as deceased | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH ? hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 25, 1965 to January 25, 1965 , that (I) (we) last saw the deceased alive on January 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Barry N. Rosenbaum | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) Barry N. Rosenbaum | | | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-28-65 | | 24C. NAME OF CEMETERY or CREMATORY Granite Presbyterian Cemetery | | 24D. LOCATION (City, town, or county) (State) Granite, Balt Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR Luther H. Haight | | ADDRESS Sykesville, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1030 | | | | BALTIMORE CITY HEALTH DEPT. | | CERTIFICATE OF DEATH | | Registered No. 65 1030 | |
|--|-------------------------|--|--|---|--|---|------------------------------------|------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <u>Betty L. Knight</u> | | | | 2. DATE AND HOUR OF DEATH <u>Jan. 28, 1965</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>120 W. Lafayette Ave.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>14-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>120 WEST LAFAYETTE Ave.</u> | | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Oct. 13, 1878</u> | 9. AGE (In years last birthday) <u>86</u> | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | | |
| 13. FATHER'S NAME <u>Isaac Short</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Arbelia Aleshire</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. Leonard Foltz 120 W. Lafayette Ave.</u> | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>174 X I</u> <u>Carinomatosis</u> <u>uterine Cancer</u> <u>Fracture LT. Hip</u> <u>Pathological Fracture</u> <u>Incontinence</u> <u>Liver Metastasis</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>3 mo.</u> <u>3 wks.</u> <u>1 mo.</u> | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1964</u> to <u>Jan. 28 1965</u> , that (I) (we) last saw the deceased alive on <u>1/26 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>K. Krulvitz</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <u>1/28/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>K. Krulvitz</u> M.D. | | | | 23D. ADDRESS <u>115 W. Monument St. (C) MD</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1 30 65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Pauls</u> | | 24D. LOCATION (City, town, or county) (State) <u>Alma, Va.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1965</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Mc Gully</u> | | ADDRESS <u>130 E. Fort Ave.</u> | |



1
M. 600

65 1031

BALTIMORE CITY HEALTH DEPARTMENT

65 1031

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JESSIE MOORE

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1965 11:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2122 Pennsylvania Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 21, 1912

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Elevator Dispatcher Houston, Texas

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George Moore

14. MOTHER'S MAIDEN NAME

Rosie Horton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
460-07-2051

17. INFORMANT

ADDRESS

Mrs. Mae Moore, 2122 Penna. Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Rheumatic Heart Disease.

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1/28/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

2/2/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem

23D. LOCATION

(City, town, or county)

(State)

Balto. Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Morton & Dyett Funeral Home Inc.

WALLEY FORGE

WALLEY FORGE

APR 12 1900

WALLEY FORGE

APR 12 1900

APR 12 1900

APR 12 1900

APR 12 1900

APR 12 1900

APR 12 1900

APR 12 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

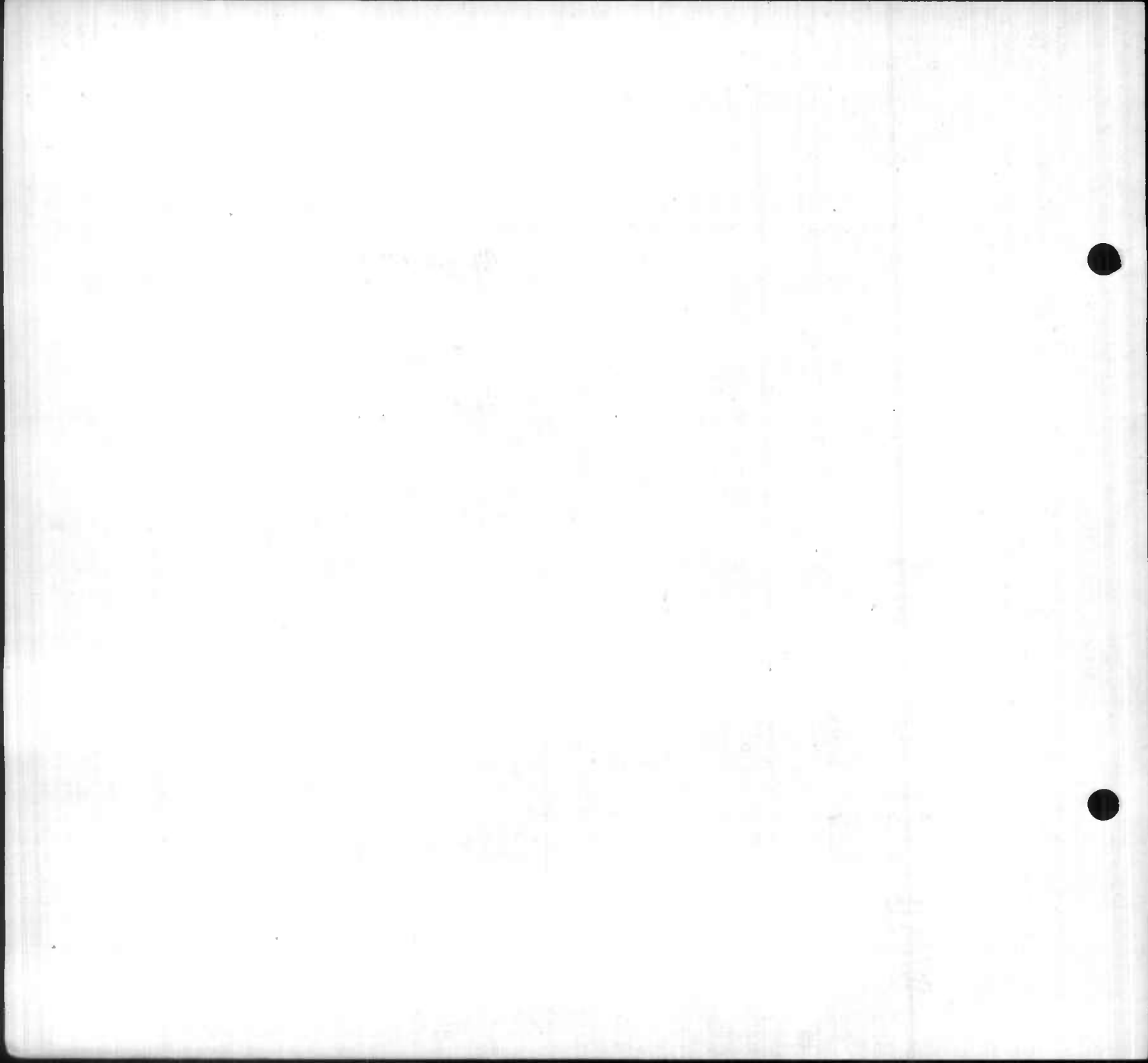
| | | | |
|--|--|---|---|
| <p>BIRTH NO. 65 1032</p> <p>CERTIFICATE OF DEATH</p> | | <p>Registered No. 65 1032</p> | |
| <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>ROYSTER, CRYSTAL A.</i></p> | | <p>2. DATE AND HOUR OF DEATH <i>1/28/65</i> <i>12:20 AM</i> M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran hosp. of Maryland</i></p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Md.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Md.</i> D. STREET ADDRESS (If rural, give location) <i>2548 OSWEGO Avenue #15</i></p> | |
| <p>5. SEX <i>female</i></p> | <p>6. RACE <i>colored</i></p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> | <p>8. DATE OF BIRTH <i>1-18-65</i></p> |
| <p>9. AGE (In years last birthday) <i>11 days</i></p> | | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i></p> | |
| <p>11. BIRTHPLACE (State or foreign country) <i>Balto Md</i></p> | | <p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i></p> | |
| <p>13. FATHER'S NAME <i>Calvin Royster</i></p> | | <p>14. MOTHER'S MAIDEN NAME <i>HELEN MORRIS</i></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO.</p> | |
| <p>17. INFORMANT <i>HELEN Royster</i></p> | | <p>ADDRESS <i>2548 OSWEGO AVE</i></p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>intestined obstruction</i></p> | | <p>INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i></p> | |
| <p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>peritonitis</i></p> | | <p>20. CAUSE OF DEATH (A) DUE TO <i>intestined obstruction</i> (B) DUE TO <i>peritonitis</i> (C) <i>ruptured small bowel</i></p> | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | |
| <p>19A. DATE OF OPERATION <i>1/21/65</i></p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intestined obstruction ruptured intestine</i></p> | |
| <p>20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <i>1-21-65</i> to <i>1-28-65</i>, that (I) (we) last saw the deceased alive on <i>1-28-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE <i>G.H. Adib M.D.</i></p> | | <p>23B. DATE SIGNED <i>1/28/65</i></p> | |
| <p>23C. PHYSICIAN'S NAME (Type) <i>G.H. Adib</i></p> | | <p>23D. ADDRESS <i>G.H. Adib M.D. Lutheran hosp of Maryland</i></p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i></p> | | <p>24B. DATE <i>1/30/65</i></p> | |
| <p>24C. NAME OF CEMETERY OR CREMATORY <i>Mt Airy</i></p> | | <p>24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i></p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1965</i></p> | | <p>25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i></p> | |
| <p>25C. FUNERAL DIRECTOR <i>Man Sings P. Hays</i></p> | | <p>ADDRESS <i>638 N. Gilmor</i></p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

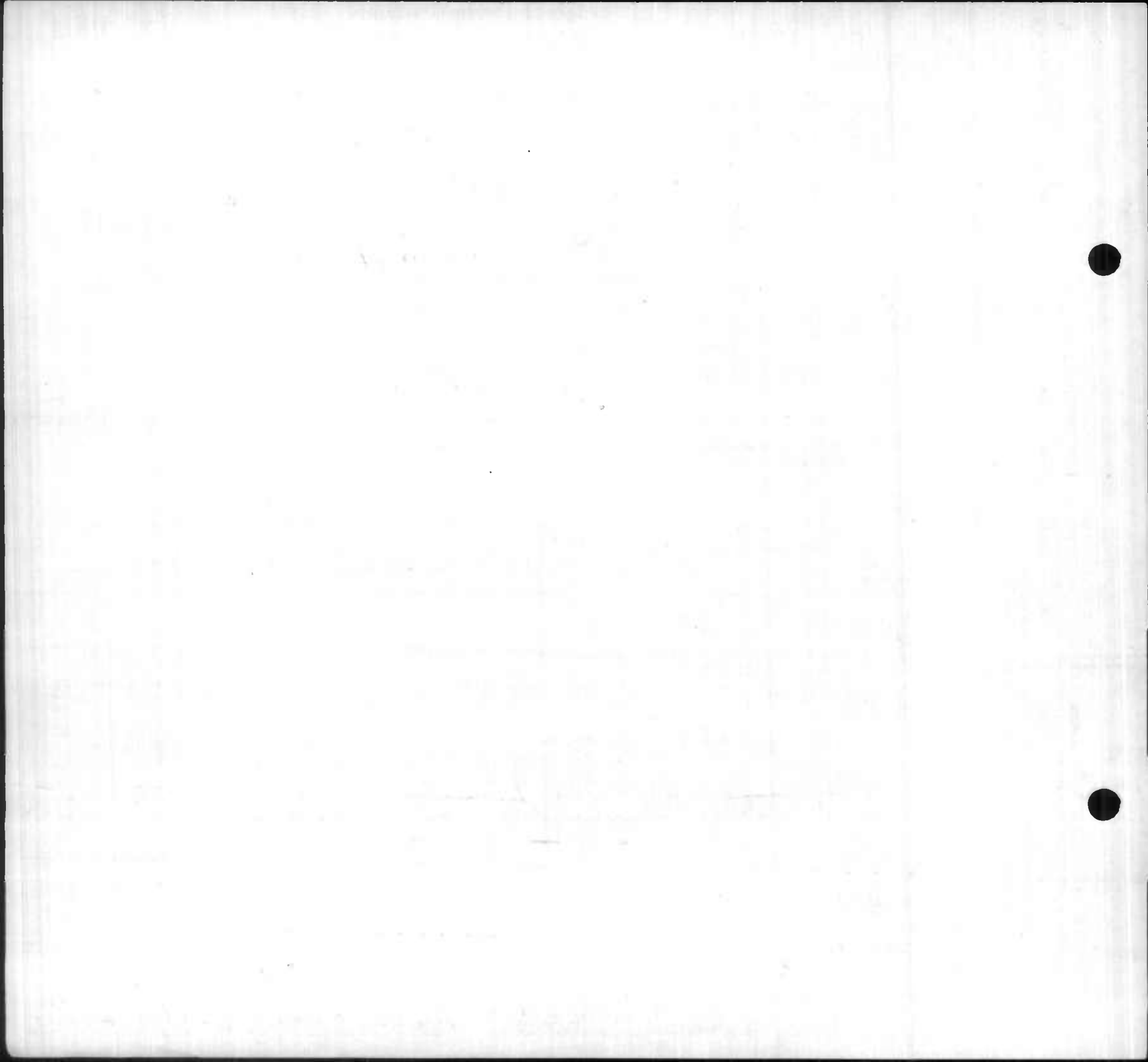
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 1033 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1033 | | | | |
| 1. NAME OF DECEASED (Type or Print) Meickey, Bernadine | | | | | 2. DATE AND HOUR OF DEATH January 27 1965 7.15PM | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 | | | | |
| 5. SEX Female | | | | | 6. RACE white | | | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 8. DATE OF BIRTH May 10 1890 | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | 9. AGE (In years last birthday) 75 | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. | | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | |
| 18. 290.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES | | | | | (A) Congestive Heart Failure DUE TO | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) Severe Anemia (Pernicious) DUE TO | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (C) | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) no | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 23 1965 to January 27 1965, that (I) (we) last saw the deceased alive on January 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Salvador Marse | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED January 27 1965 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Salvador Marse | | | | | 23D. ADDRESS M.D. 1400 N. Caroline St. Baltimore 21213 Md. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 1-30-65 | | | | | 24C. NAME of CEMETERY or CREMATORY New Cathedral | | | | |
| 24D. LOCATION (City, town, or county) Baltimore | | | | | 24E. NAME OF REGISTRAR Robert E. J. J. J. | | | | | 24F. FUNERAL DIRECTOR Seal & Clerk | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. J. J. J. | | | | | 25C. FUNERAL DIRECTOR Seal & Clerk | | | | |
| 25D. ADDRESS 1701 N. Patterson | | | | | 25E. ADDRESS 1701 N. Patterson | | | | | 25F. ADDRESS 1701 N. Patterson | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

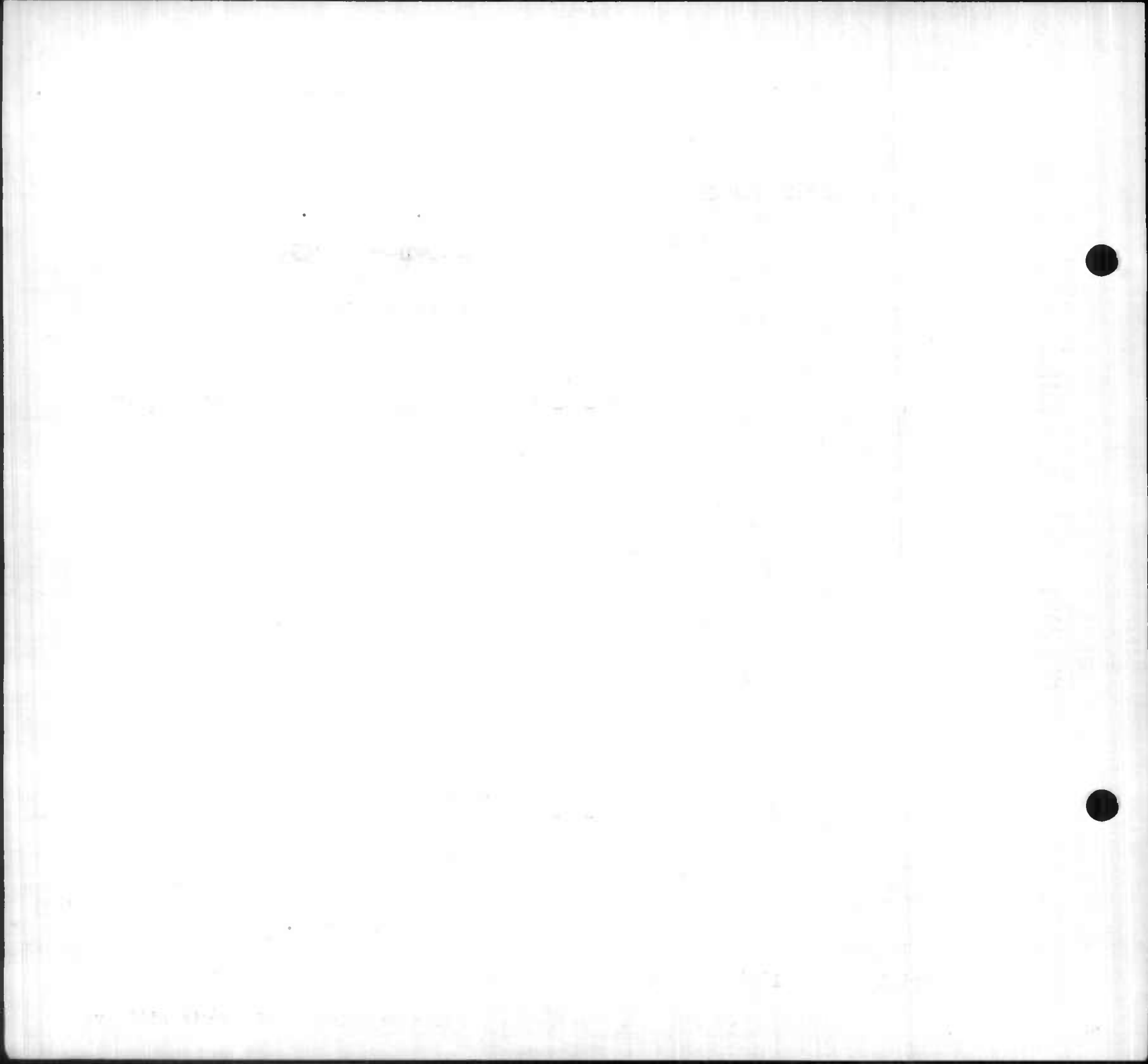
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1034 | |
|--|--|--|---|------------------------|--|
| BIRTH NO. 65 1034 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ANNA MASILONIS | | | 2. DATE AND HOUR OF DEATH January 27, 1965 9:30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4223 Bayonne Ave | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 26-01 | | |
| 5. SEX Fem 6. RACE Wh 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | 8. DATE OF BIRTH MAR 7-1891 9. AGE (In years last birthday) 73 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) LITH | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Home | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME CHARLES PLUNKIS | | | 14. MOTHER'S MAIDEN NAME — | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | 16. SOCIAL SECURITY NO. — | | |
| 17. INFORMANT Mrs Viola Prince - 4223 Bayonne Ave | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X I Pulmonary Edema | | | CAUSE OF DEATH (A) DUE TO Pulmonary Edema | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH (B) DUE TO Cardio-Vascular Hypertensive Disease 14 years (C) Arteriosclerosis 14 years | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 1963 to January 27, 1965 , that (I) (we) last saw the deceased alive on January 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael J. Dausch | | | 23B. DATE SIGNED 1-28-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Michael J. DAUSCH | | | 23D. ADDRESS 4636 Belair Road. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-30-65 | | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem | | | 24D. LOCATION (City, town, or county) (State) Barto Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | |
| 25C. FUNERAL DIRECTOR Thomas J. Kenney | | | ADDRESS 1600 Hillman | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|------------------|---|--|---|--|---|--|---|--|--|
| BIRTH NO. 65 1035 | | | | | CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 1035 | | | | | |
| 1. NAME OF DECEASED (Type or Print) John Bell | | | | | 2. DATE AND HOUR OF DEATH 1-26-65 4:25 p.m. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1802 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 27 N. Carey St. | | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | | 8. DATE OF BIRTH 4-7-1901 | 9. AGE (In years last birthday) 63 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11. BIRTHPLACE (State or foreign country) South Carolina | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Sam Bell | | | | | 14. MOTHER'S MAIDEN NAME Fannie Bell | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 218-03-5264 | | 17. INFORMANT Mrs Esther Blue 28g Herring Court | | | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Old CVA + knee malnutrition + dehydration | | | | | INTERVAL BETWEEN ONSET AND DEATH 2:00 pm - 4:25 pm | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-26-65 19 to 1-26-65 19 that (I) (we) last saw the deceased alive on 1-26-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Ruperto Manankil M.D. | | | | | 23B. DATE SIGNED 1-26-65 | | | 23C. PHYSICIAN'S NAME (Type) Ruperto Manankil M.D. | | |
| 23D. ADDRESS 1514 Division St. | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | | | 24D. LOCATION (City, town, or county) (State) A A County Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Carley M.D. | | 25C. FUNERAL DIRECTOR Adolphus Halstead 918 Druid Hill Ave | | | |

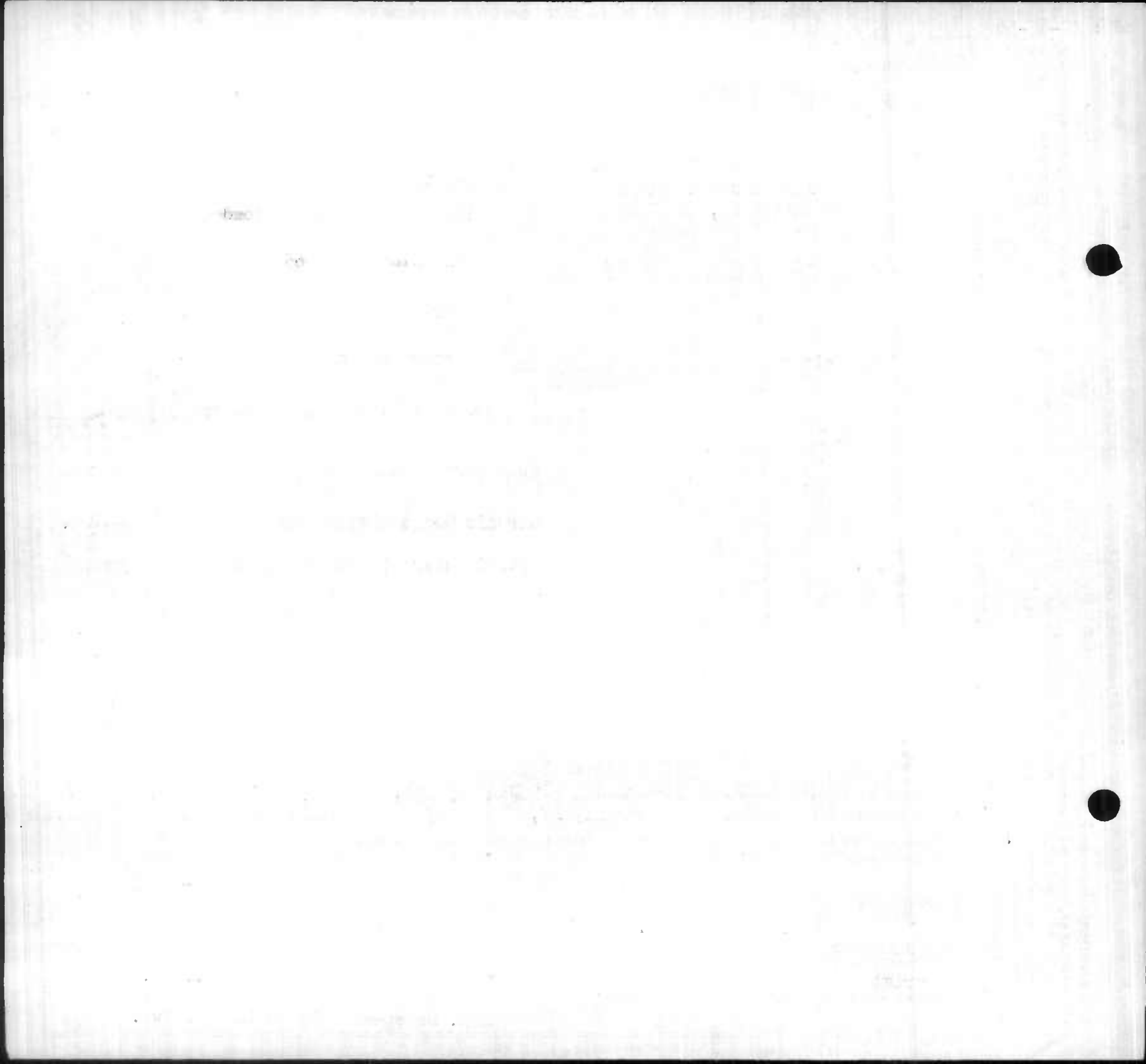


edg: 42-68-561

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

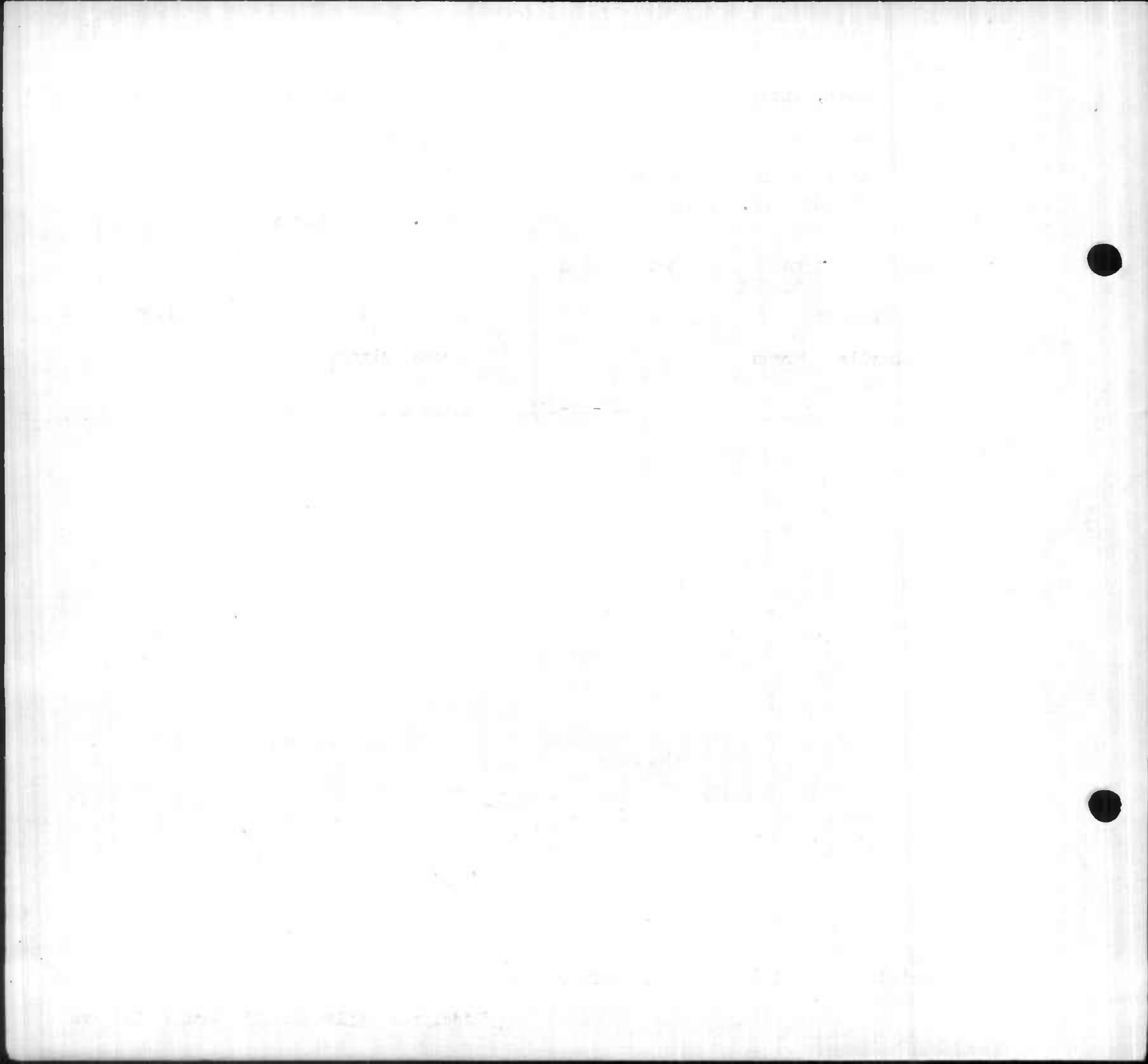
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1036 | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 65 1036 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Amelia Nelson | | | January 27, 1965 7:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland | | | A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 106 South Calverton Road | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1-16-1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Elliott Nelson | | | 14. MOTHER'S MAIDEN NAME Betty Whalen | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Emboli DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 6 hours | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Chronic Congestive Failure DUE TO 8 months | | |
| | | | (C) Arteriosclerotic Heart Disease 12 years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 24, 1965 to January 27, 1965 , that (I) (we) last saw the deceased alive on January 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>H. Rathbun</i> | | | | 23B. DATE SIGNED 1-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Howard K. Rathbun M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Ann Arundel Cty., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS A. Halstead 918 Druid Hill Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1037 | |
|---|-------------------------|--|------------------------------|--|---|
| BIRTH NO. 65 1037 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Brown, Luther | | January 27, 1965 3:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION George Washington Carver Nursing Home 607 Penn. Avenue | | A. STATE Maryland B. COUNTY 16-04 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 606 N. Monroe Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH ? | 9. AGE (In years last birthday) ? 65 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | 13. FATHER'S NAME Charlie Brown | | | |
| 14. MOTHER'S MAIDEN NAME Ferbee dixon, | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | | |
| 16. SOCIAL SECURITY NO. 237-14-2111 | | 17. INFORMANT Chart 414 607 Pennsylvania Avenue | | | |
| 18. 443X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Cerebral vascular accident | | | |
| ANTECEDENT CAUSES | | (B) DUE TO Hypertensive arteriosclerosis 2 yrs | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Cardiovascular disease | | | |
| II | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/4 19 64 to 1/27 19 65 , that (I) (we) last saw the deceased alive on 1/26/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. N. Mac Morthy | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) J. N. MAC MORTHY | | 23D. ADDRESS 500 E Madison St 2nd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/29/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION A A County Md | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Halstead | | 25C. FUNERAL DIRECTOR Adolphus Halstead 918 Druid Hill Ave | | | |



1

65 1038

BALTIMORE CITY HEALTH DEPARTMENT

65 1038

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

59210

1. NAME OF DECEASED

(Type or Print)

JAMES MANLEY

2. DATE AND HOUR PRONOUNCED DEAD

1 January 1965

9:58 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Josephs Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

603 E. Chase Bt.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

45

11 Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Intestinal obstruction (small bowel)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) strangulated inguinal hernia
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes-partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/2/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

JAN 18 1965

23C. NAME OF CEMETERY, CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

100-100000-100000

WALTON, J. H.

100-100000-100000

BIRTH NO. 65 1039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VERNON

BOWMAN

2. DATE AND HOUR PRONOUNCED DEAD

January 28, 1965

7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1935 Ridgehill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec 13-1906

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

City Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Bowman

14. MOTHER'S MAIDEN NAME

Bertina Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Louise Bowman

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cirrhosis and Hypertensive Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/28/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/31/65

23C. NAME OF CEMETERY or CREMATORY

Arlington Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Choy A. Wilson 100 Beantley

ADDRESS

WALLACE & GROMBE

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Irene Moses

2. DATE AND HOUR OF DEATH

January 27, 1965

4 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

229 S. Bethel Street #21231

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-15-02

9. AGE (In years
last birthday)

62

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.

(A) Cerebral Vascular Accident

1 Year

DUE TO

Arteriosclerotic Cardio Vascular
Disease

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-29 19 64 to 1-27 19 65
that (I) (we) last saw the deceased alive on 1-27 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. H. Rathbun

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-27-65

23C. PHYSICIAN'S
NAME (Type)

Dr. H. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/1/65

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cmt

24D. LOCATION

Brooklyn

(City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Clroy O. Wilson 1070 Brantley Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

65 1041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1041

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anothy OLSZEWSKI

2. DATE OF DEATH

Jan 16, 1965

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Century Home
102 N. Paca St.

Balto., Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

102 N. Paca St.

D. STREET ADDRESS

(If rural, give location)

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1/6/92

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10. A. USUAL OCCUPATION (Give kind of
work done during most of working life, even
if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

443 X 1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Cardio Respiratory Failure
DUE TO Cerebral Vascular Hemorrhage, massive(B) Hypertensive - arteriosclerotic CVD
DUE TO Gen. Arteriosclerosis

(C) Cerebral Vascular Hemorrhage, old

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (NOTIFY MEDICAL EXAMINER)21b. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg, etc.)21c. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME
OF INJURY

(Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 12 1964 to Jan 16 1965, that (I) (we) last saw the deceased alive on Jan 16 1965 and that in (my) (our) opinion death occurred at 7:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23b. ADDRESS

M. D. 5401 Park Heights Rd

23c. DATE SIGNED

1/16/65

24a. BURIAL, CREMATION,
REMOVAL (Specify)

24b. DATE

JAN 28 1965

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION

(City, town, or county)

(State)

25a. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

25b. NAME OF REGISTRAR

Robert E. Farber M.D.

25c. FUNERAL DIRECTOR

MORTUARY SERVICE - BCIH

ADDRESS

VS 150

THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1042 | |
|--|--------------|--|-----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1042 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ROBERT SWANSON OSBORNE | | 2. DATE AND HOUR OF DEATH 1/18/65 7:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 301 ST. PAUL ST. 21201 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 11 NORTH HIGH ST. BALTIMORE, MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5-01 D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10/2/05 | 9. AGE (In years lost birthday) 59 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 3220 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) WERNICKE'S DISEASE DUE TO PNEUMONIA (B) DUE TO ALCOHOLISM, ACUTE & CHRONIC (C) | | INTERVAL BETWEEN ONSET AND DEATH Days. - Wks. 4 DAYS 20 YEARS + | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes) or No Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/15 1965 to 1/18 1965, that (I) (we) last saw the deceased alive on 1/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William S. Byers, M.D. | | | | 23B. DATE SIGNED 1/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM S. BYERS | | 23D. ADDRESS MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) JAN 22 1965 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BOND | |

Called Dr. said patient had Encephalitis
but not Wernicke & did not have pneumonia
either will call us after checking autopsy

B. L.

7/2/65

65 1043

BALTIMORE CITY HEALTH DEPARTMENT

65 1043

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY T. PINDER

2. DATE AND HOUR PRONOUNCED DEAD

January 22, 1965 6:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY 11-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

303 W. Biddle Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

4-28-1895 69

9. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retire

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas H. Pinder

14. MOTHER'S MAIDEN NAME

Sarah P

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

W.W.I 1918

16. SOCIAL
SECURITY NO.

213-20-4630

17. INFORMANT

Sarah Scott 303 W. Biddle St.

ADDRESS

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-27-65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem Belts

23D. LOCATION

(City, town, or county)

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Rayner Sanders 217 E. Preston St

ADDRESS

WALLACE BOWEN

WALLACE BOWEN

WALLACE BOWEN

1

65 1044 BALTIMORE CITY HEALTH DEPARTMENT 65 1044

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHRISTOPHER MON ROE

2. DATE AND HOUR PRONOUNCED DEAD 1-24-65 3:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-04

D. STREET ADDRESS (If rural, give location) 421 E. 23rd Street - 21218

5. SEX Male

6. RACE Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sep

8. DATE OF BIRTH 10-12-1890

9. AGE (In years last birth day) 75

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Rah. Monroe

14. MOTHER'S MAIDEN NAME Julian Monroe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Maken 421 E 23rd St

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) ~~X~~ Hypertensive arteriosclerotic cardiovascular disease

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE PETER W. RIECKERT, M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 1-25-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 1-28-65

23C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.

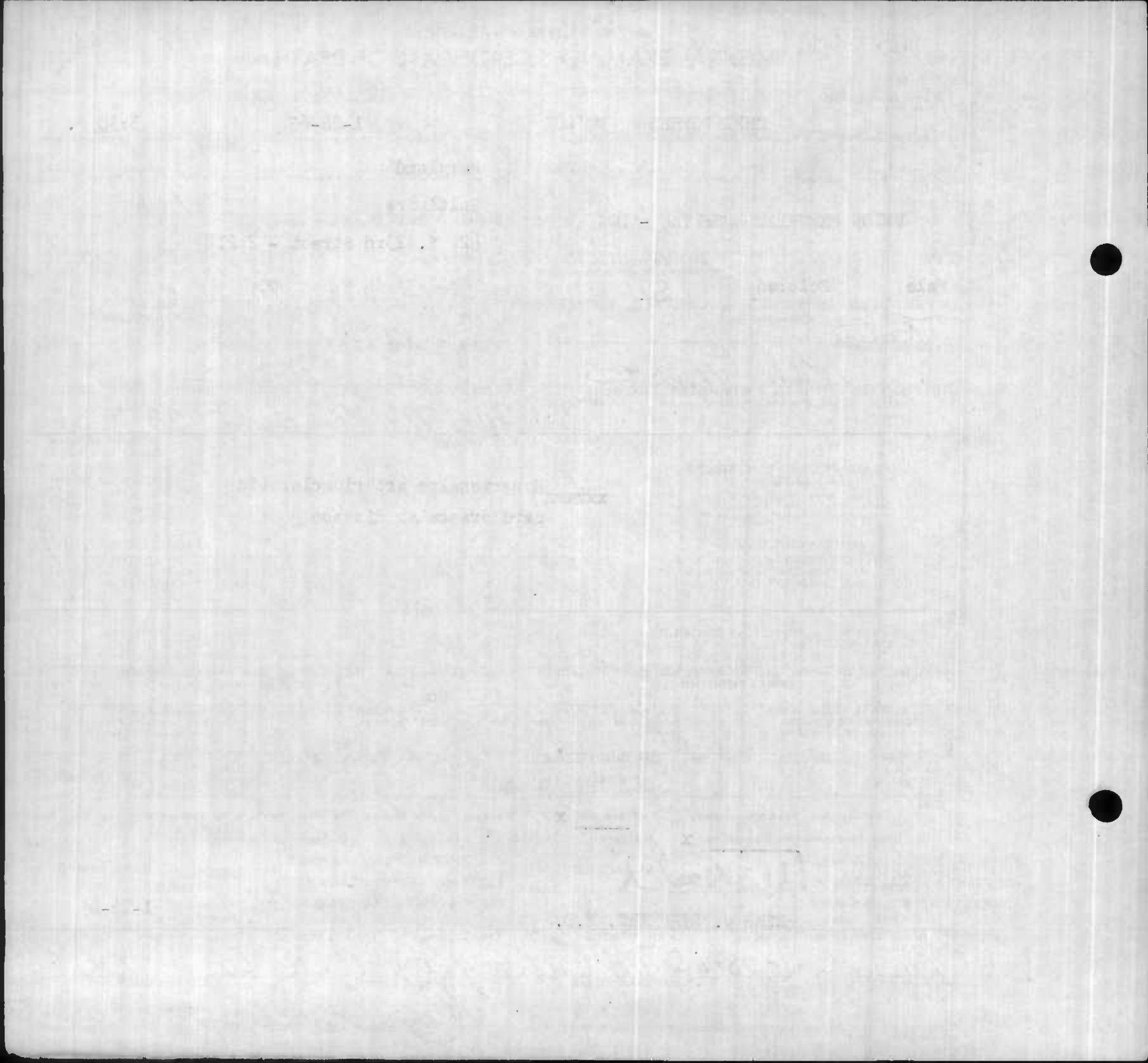
23D. LOCATION (City, town, or county) (State) A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT. JAN 29 1965

24B. NAME OF REGISTRAR Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR Rayner Sanders

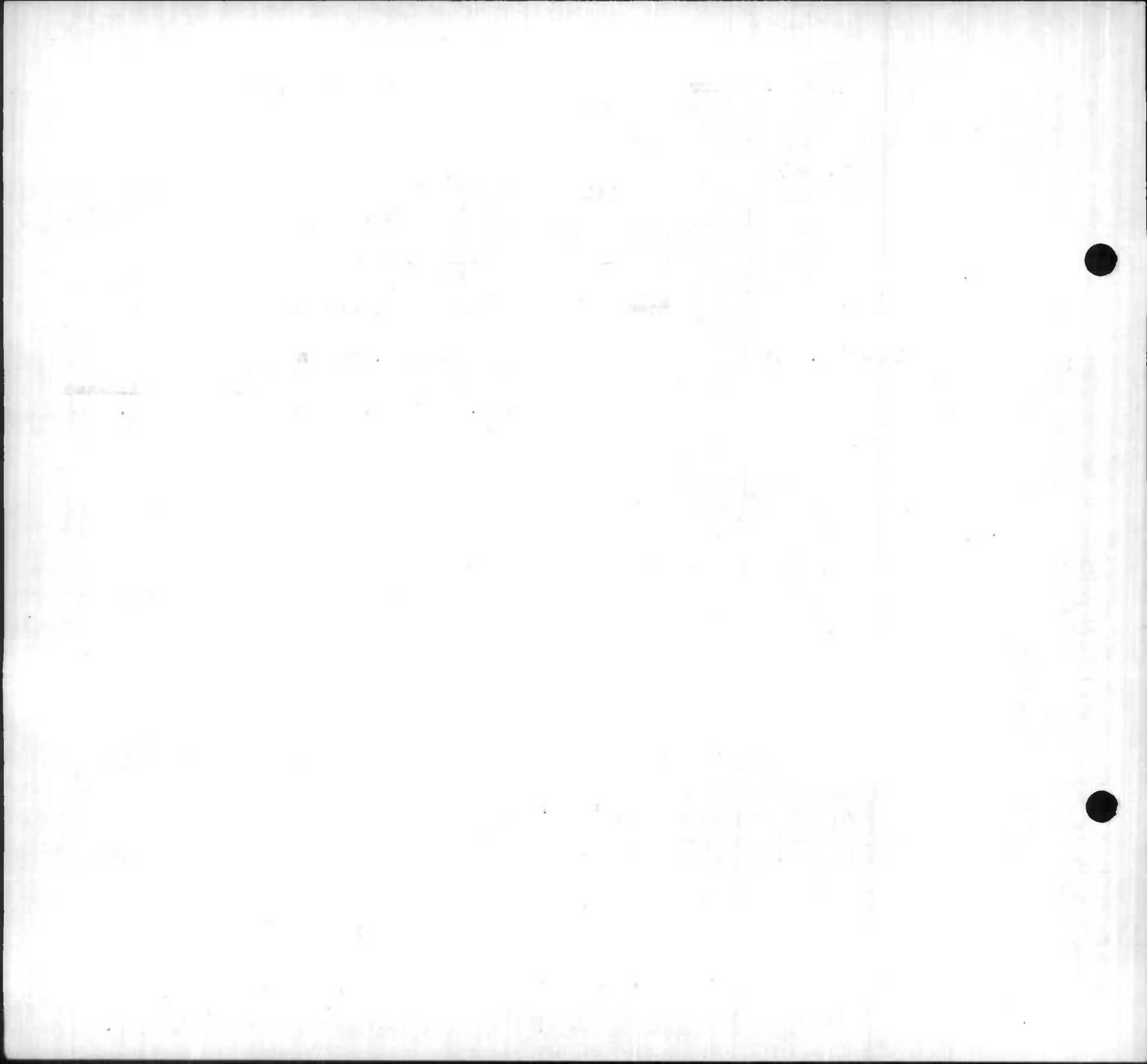
ADDRESS 217 E. Preston St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 1045 | |
|---|--|--|--|--|---|
| BIRTH NO. 65 1045 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Laura M. Taylor | | | 2. DATE AND HOUR OF DEATH January 28, 1965 11:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 504 Orkney Road Baltimore, Maryland 21212 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 504 Orkney Road 12 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH April 20, 1875 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Richard H. James | | | 14. MOTHER'S MAIDEN NAME Sarah M. Wilson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS 1217 Roundhill Road Mr. Arthur W. Taylor Baltimore, Md. 21218 | | |
| 18. 4-22-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Myocarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arterio-sclerosis | | | CAUSE OF DEATH (A) Chronic Myocarditis DUE TO (B) ✓ DUE TO (C) ✓ INTERVAL BETWEEN ONSET AND DEATH many months | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Generalized Arterio-sclerosis many months | | |
| 19A. DATE OF OPERATION 0 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓ | 20A. AUTOPSY? (Yes or No) NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 21, 1964 to Jan. 28, 1965 , that (I) (we) last saw the deceased alive on Jan. 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frank N. Ogden | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED Jan. 29, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN | | | 23D. ADDRESS M.D. 2701 N. Calvert St, Balto 18, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/1/1965 | 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | 25C. FUNERAL DIRECTOR ADDRESS Wm. J. Jucker & Sons North Pa. Avenue Baltimore, Md. 17 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1046 | |
|---|------------------|---|-----------------------------------|---|--|
| BIRTH NO. 65 1046 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Flannery, June | | 2. DATE AND HOUR OF DEATH 1/27/65 11:55A | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hosp. | | A. STATE Maryland B. COUNTY 26-11 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 3300 Foster Avenue | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/1/39 | 9. AGE (In years last birthday) 25 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME FRANCIS J. KERNAN | | 14. MOTHER'S MAIDEN NAME DOROTHY BARNES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 464X I | | CAUSE OF DEATH (A) Cardiac Arrest DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 0 | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Pulmonary Embolism DUE TO 48 hours | | | |
| | | (C) pelvic thrombophlebitis one week | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1/25/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Embolism | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 1/25 19 65 to 1/27 19 65 , that (we) last saw the deceased alive on 1/27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Azar | | | | 23B. DATE SIGNED 1/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Cornell H. Azar | | | | 23D. ADDRESS Johns Hopkins Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-30-65 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM. | |
| 24D. LOCATION (City, town, or county) (State) BALTO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Walter Miller | |
| | | | | ADDRESS 2334 Jefferson St. | |



cdg: 42-51-491

M.62-20

990

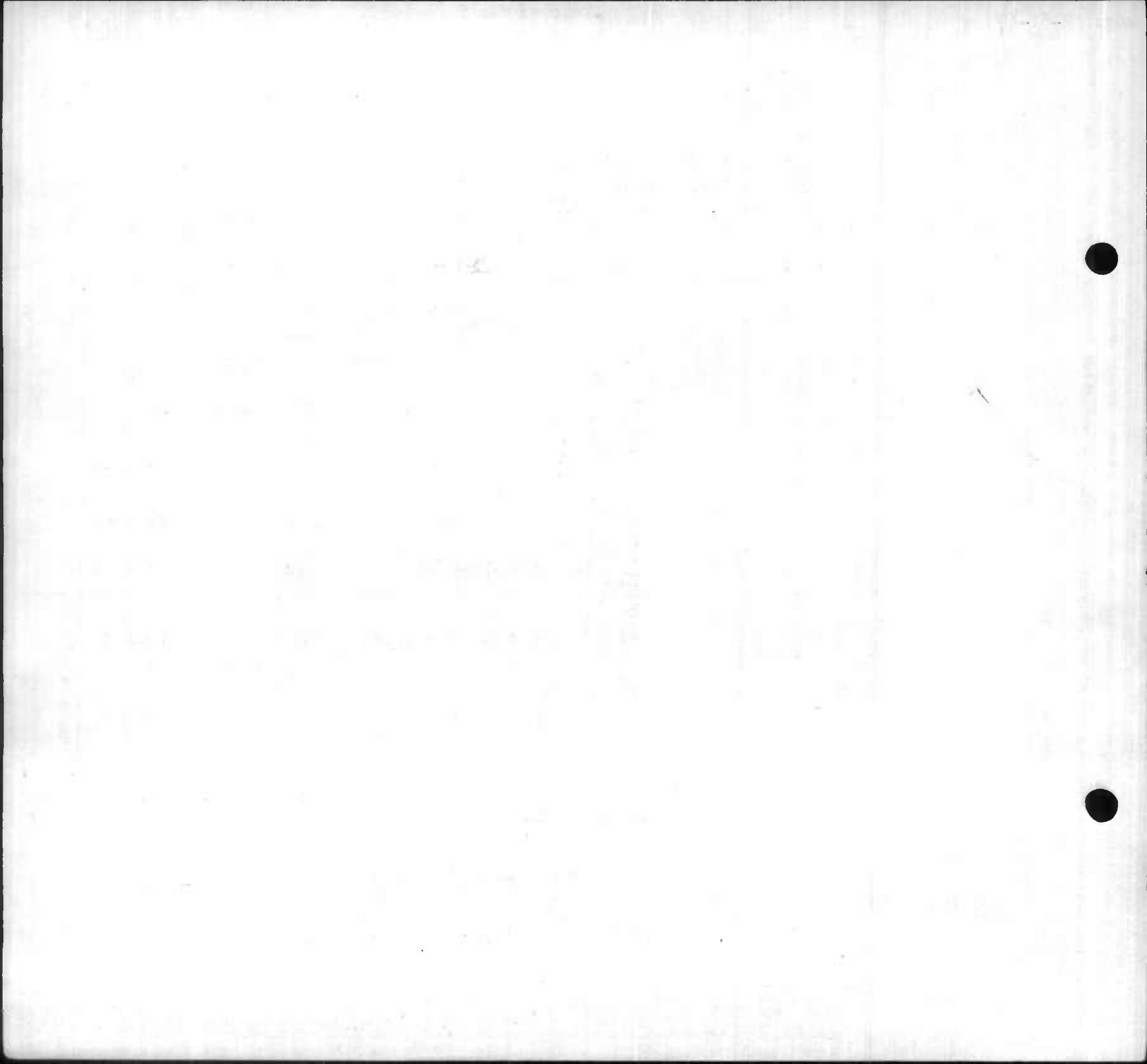
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 65 1047

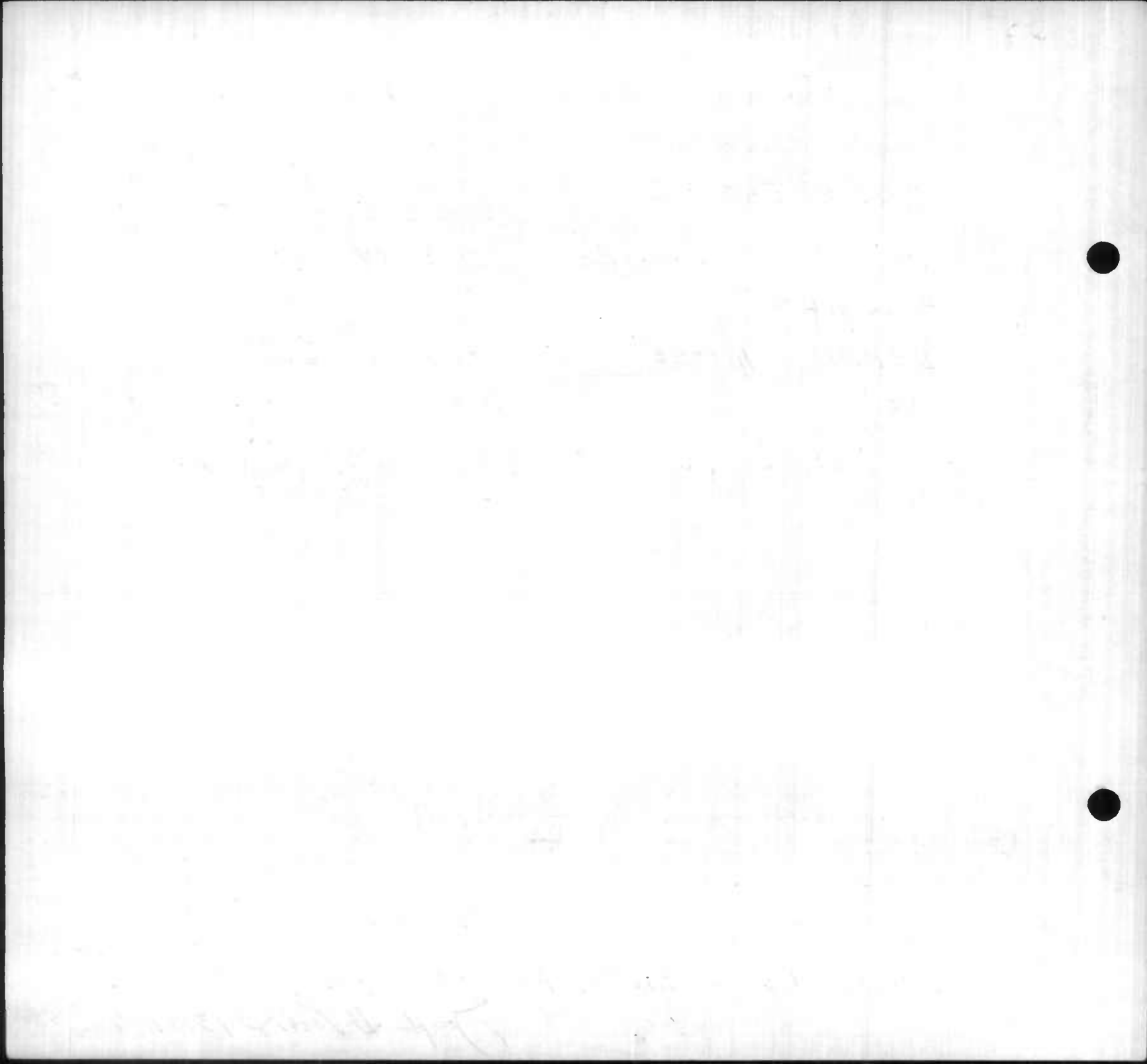
| | | | |
|---|----------------------|---|--|
| BIRTH NO. 65 1047 | | M.E. CASE NO. 59423 | |
| 1. NAME OF DECEASED (Type or Print) M. Anna Morrissey | | 2. DATE AND HOUR OF DEATH January 27, 1965 1:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 619 North Potomac Street | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 2-13-78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | 9. AGE (In years last birthday) 86 |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CHARLES PHILLIPS | | 14. MOTHER'S MAIDEN NAME CATHERINE PARR | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. RECORDS: BCH 4940 Eastern Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X4E903.0 Hip Fracture | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebrovascular Accident | | 2 1/2 weeks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia & Urinary Tract Infection | | 1 week | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 21C. WHERE DID INJURY OCCUR? Bedroom - Home | | 21D. TIME OF INJURY (APPROX.) 1-2-65 10:30 PM | |
| 21E. INJURY OCCURRED White At Work | | 21F. HOW DID INJURY OCCUR? fall to floor | |
| 22. I certify that (I) (this hospital) attended the deceased from January 5, 1965 to January 27, 1965 , that (I) (we) lost saw the deceased alive on January 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE James R. Leonard | | 23B. DATE SIGNED 1-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) James R. Leonard | | 23D. ADDRESS 4940 Eastern Avenue 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-30-65 | |
| 24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM. | | 24D. LOCATION (City, town, or county) (State) BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR Stanley Miller | | 25D. ADDRESS 2334 Jefferson St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1048 | |
|--|--|--|---|--|--|
| BIRTH NO. 65 1048 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | BLANCHE BOULDIN | | 1-26-65 7:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2003 E. EAGER ST | | | A. STATE Md. B. COUNTY 7-04 | | |
| 5. SEX F. | | | 6. RACE C. | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 12-8-94 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 9. AGE (In years last birthday) 70 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Md. | | |
| 13. FATHER'S NAME DENNIS MOORE | | | 12. CITIZEN OF WHAT COUNTRY? US | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 14. MOTHER'S MAIDEN NAME ANNABELL SMITH | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT LEROY BOULDIN 2003 E. EAGER ST | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X I HYPERTENSIVE CARDIOVASCULAR DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH ? | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 10 1964 to Jan 26 1965; that (I) (we) last saw the deceased alive on Jan 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. K. ADAMS | | | 23B. DATE SIGNED 1-29-65 | | |
| 23C. PHYSICIAN'S NAME (Type) F. K. ADAMS | | | 23D. ADDRESS 1222 N. Caroline St Baltimore | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/30/65 | | 24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM. PK. | |
| 24D. LOCATION Arbutus, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Joseph H. Lockhart | | 25D. ADDRESS 1304 N. Central Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-----------|--|------------------|--|------------------------|--|------------------------------|
| BIRTH NO. 65 1049 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1049 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MABEL AGUILLA | | | | 1-28-65 10:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 1627 N. Wolfe St | | | | MD | | 506 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| BALTO. | | | | 1627 N. Wolfe ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months | 11. UNDER 24 Hrs. Days | 12. CITIZEN OF WHAT COUNTRY? |
| F. | C. | MARRIED | 5-11-06 | 58 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | MD | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| ALBERT WHITE | | | | JEANNETTE COOPER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | 218-03-3071 | | Larry Aguilla 1627 N. Wolfe St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Acute Cerebral Thrombosis | | Instant | |
| 19. ANTECEDENT CAUSES | | | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Arterio Sclerosis | | 4 Years | |
| | | | | (B) DUE TO | | | |
| | | | | Hypertension (Essential) | | ? | |
| | | | | (C) DUE TO | | | |
| | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 1-8-1960 to 1-1-28-1965 , that (I) (we) last saw the deceased alive on 1-25-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Eugene H. Orlin | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Eugene H. Orlin | | | | 1735 E. Federal St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 2/1/65 | | MT. CALVARY | | A.A. County, MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 29 1965 | | Robert E. Fisher | | Joseph B. Rock | | 1304 N. Central Ave | |

with 1/2 cup of oil
and 1/2 cup of sugar
and 1/2 cup of water

and 1/2 cup of oil
and 1/2 cup of sugar
and 1/2 cup of water

R 240

65 1050

BALTIMORE CITY HEALTH DEPARTMENT

65 1050

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HUBERT RUSSELL(HUBERT JOSEPH RUSSELL

2. DATE AND HOUR PRONOUNCED DEAD

January 25, 1965

3:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2016 St. Paul Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Dec. 11, 1925

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Keyser West Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Hugh Russell

14. MOTHER'S MAIDEN NAME

Frances Fahey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes 4/22/44 10/31/46 213

16. SOCIAL
SECURITY NO.

22 4362

17. INFORMANT

RT. # Two Trails End. Manitowoc Wis.
Mrs Julie G. Wagner

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/1/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

HENRY SANDER & SONS INC.

ADDRESS

BALTIMORE Maryland 21213

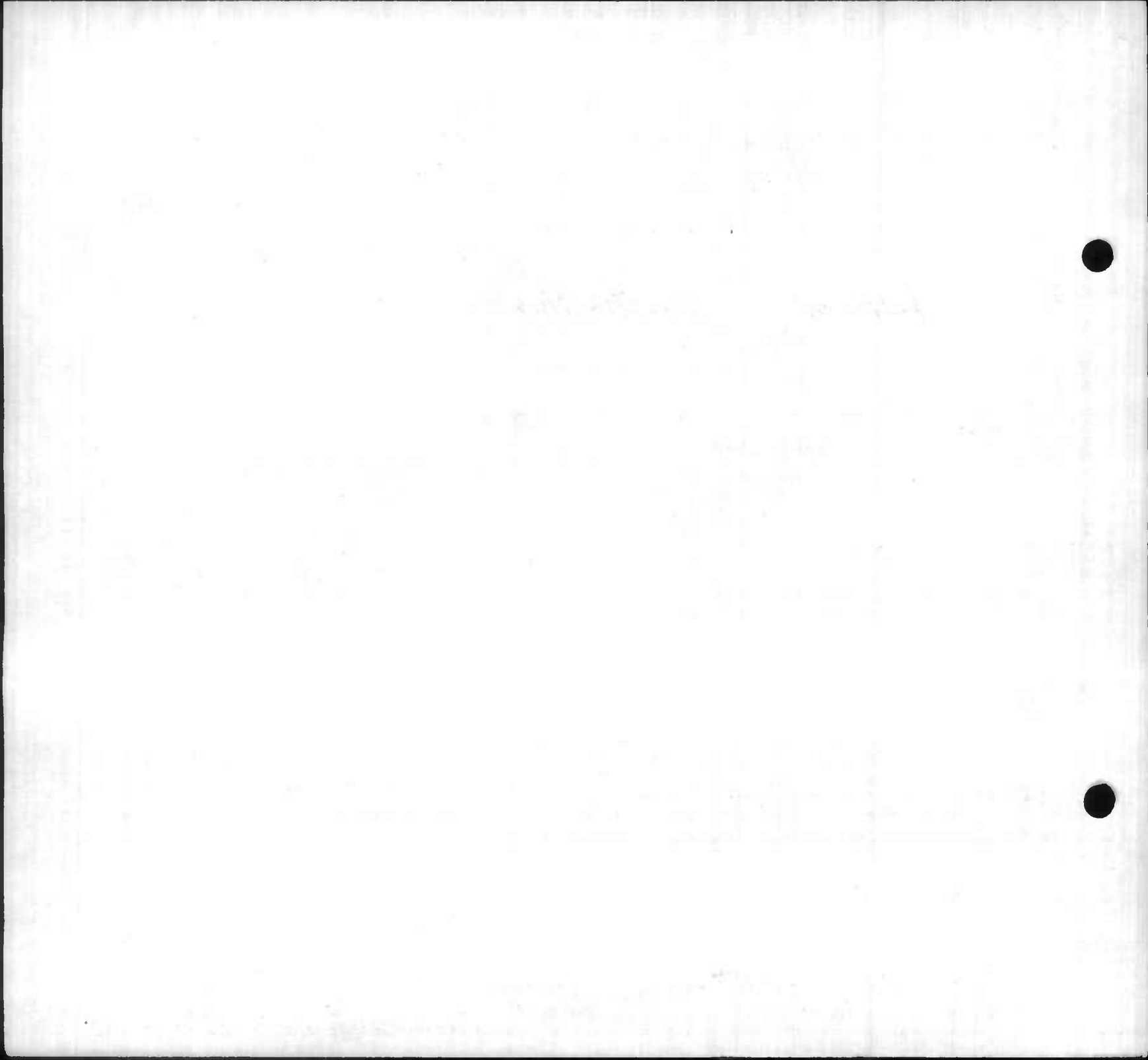
WALLER PIONEER

MANUFACTURED BY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

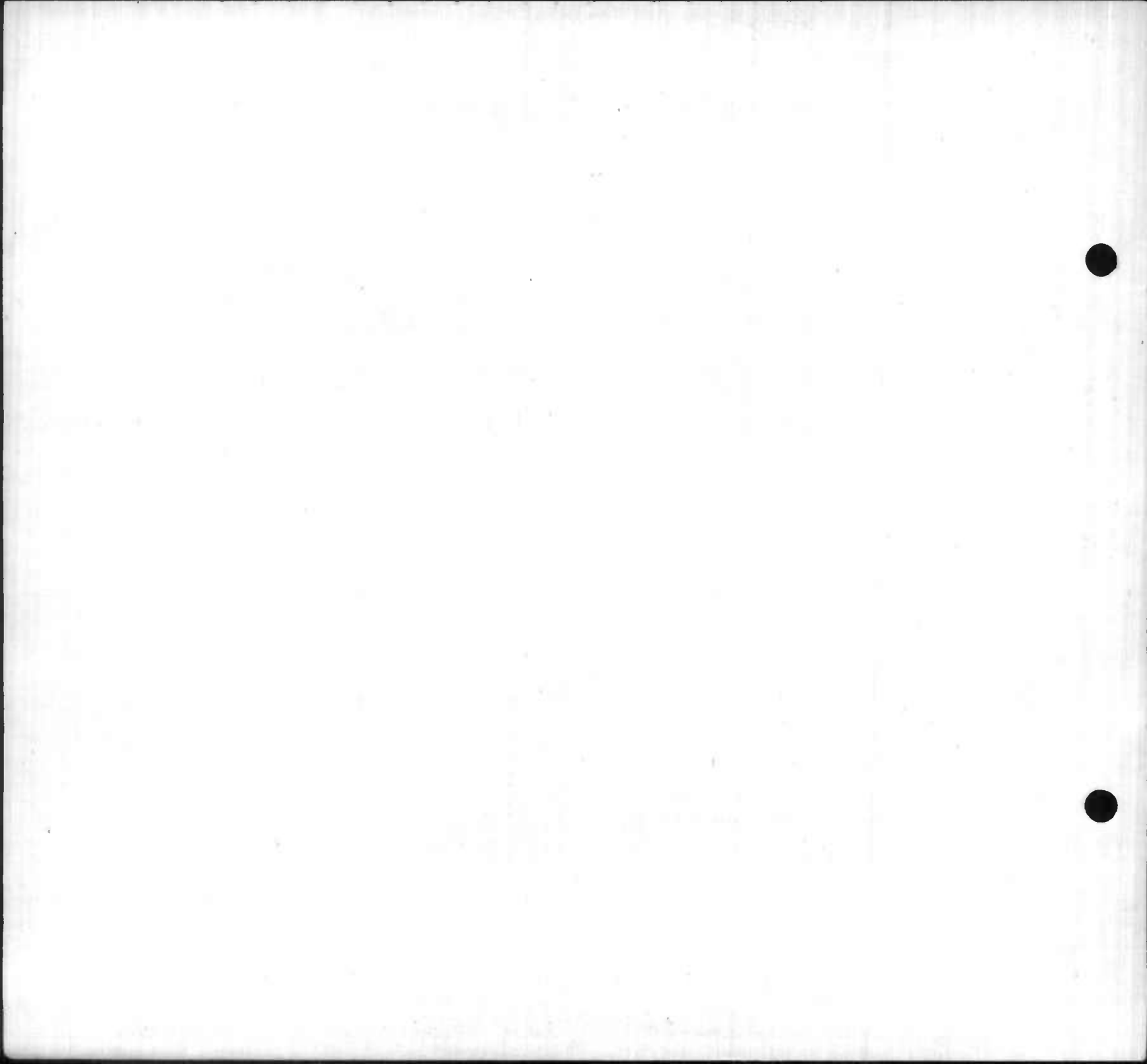
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1051 | |
|---|-------------------------|--|---|--|--|--|---|--|--|----------------------------------|--|
| BIRTH NO. 65 1051 | | | | | | | | | | 65 1051 | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>William ELIJAH DEMONIA</i> | | | | | 2. DATE AND HOUR OF DEATH <i>1-27-65 6⁴⁵ P M.</i> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIVERSITY HOSPITAL</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>664 W. FAYETTE ST.</i> | | | | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED (Sep)</i> | 8. DATE OF BIRTH <i>10-10-12</i> | 9. AGE (In years last birthday) <i>52</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 11. BIRTHPLACE (State or foreign country) <i>S.C., Manning</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | |
| 13. FATHER'S NAME <i>William DEMONIA</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Cammie</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | | 16. SOCIAL SECURITY NO. <i>251-01-6567</i> | | 17. INFORMANT ADDRESS <i>HOSPITAL RECORDS</i> | | | | |
| 18. <i>332 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>BASILAR ARTERY THROMBOSIS 5 weeks</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>CEREBRAL ATHEROSCLEROSIS UNKNOWN</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-14-1964</i> to <i>1-27-65</i> that (I) (we) last saw the deceased alive on <i>1-27-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>James J. McPhillips</i> | | | | | | | | | 23B. DATE SIGNED <i>1-27-65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JAMES J. McPHILLIPS</i> | | | | | | | | | 23D. ADDRESS <i>University Hospital</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>Jan 30 1965</i> | | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Jackson, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i> | | | 25D. ADDRESS <i>318 N. Schneider St.</i> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

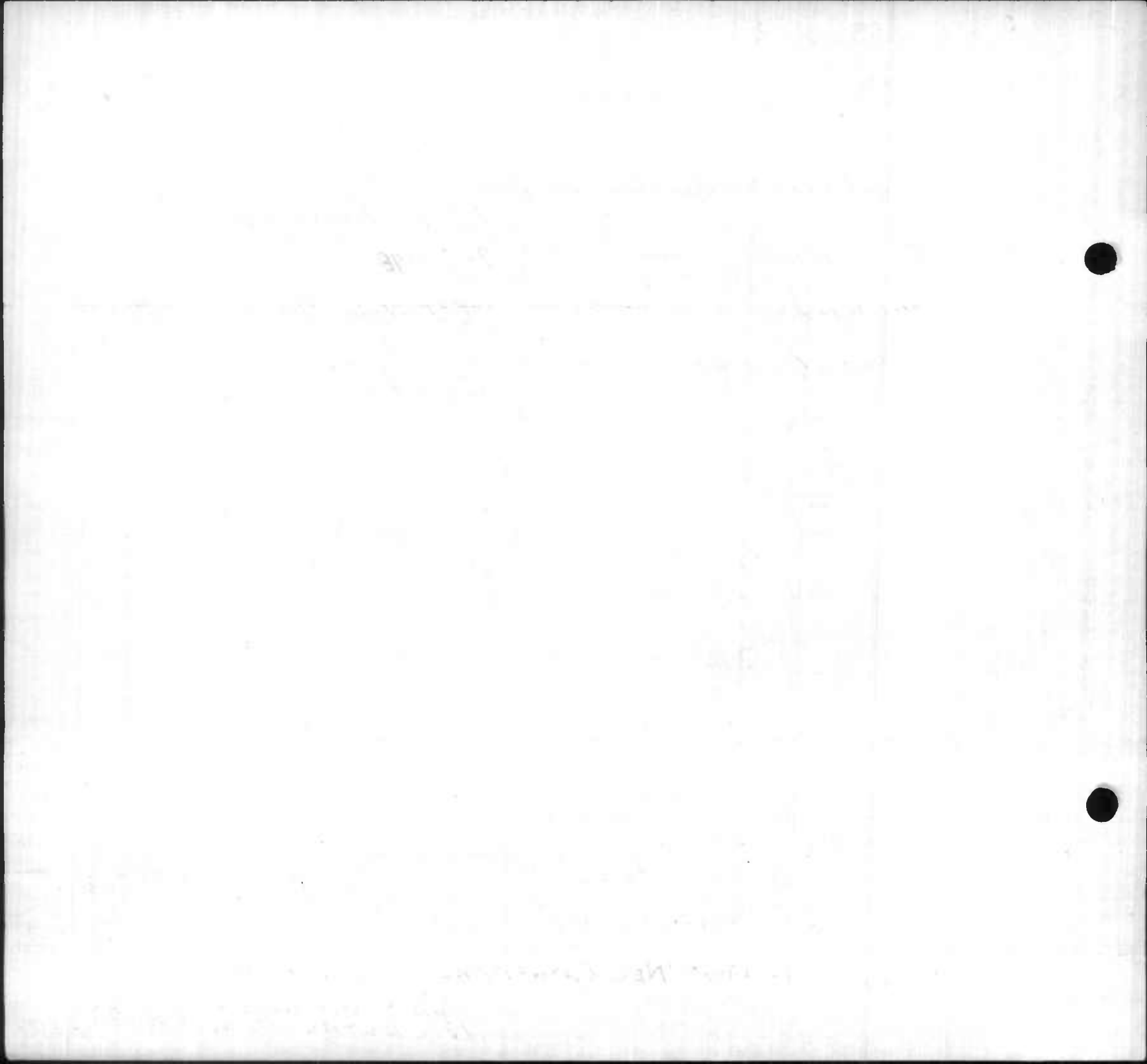
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 1052 | | | | | REGISTERED NO. 65 1052 | | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Pietro DORTONA</u> | | | | | 2. DATE AND HOUR OF DEATH <u>1/28/65</u> <u>2:50</u> <u>P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> | | | | | A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 7</u> | | | | | |
| 5. SEX <u>m</u> 6. RACE <u>w</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>m</u> | | | | | D. STREET ADDRESS (If rural, give location) <u>1105 Granville Rd.</u> | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>ITALY</u> | | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>UNKNOWN DORTONA</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | | 16. SOCIAL SECURITY NO. <u>179-07-8191</u> | | | | | |
| 17. INFORMANT <u>ANNA DORTONA</u> | | | | | ADDRESS <u>1105 GRANVILLE RD</u> | | | | | |
| 18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>CONGESTIVE HEART FAILURE</u> (B) <u>ARTEROSCLEROTIC HEART DISEASE</u> (C) _____ | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Vicente R. Carag Jr.</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>Jan. 28/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>VICENTE R. CARAG JR.</u> | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 24B. DATE <u>1-30-65</u> | | | 24C. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM</u> | | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME 5311 EDMONDSON AVE</u> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1053 | |
|---|------------------|---|------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 65 1053 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Margaret Bernadine Finch | | | | 2. DATE AND HOUR OF DEATH 1-27-65 | | T. 15 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Maryland | | B. COUNTY 11-02 | |
| C. CITY OR TOWN Baltimore | | | | D. STREET ADDRESS 1331 Park Ave. | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 7-3-1878 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Westminster, Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward Augustus Shewen | | | | 14. MOTHER'S MAIDEN NAME Lynch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) — | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital Admission Sheet | |
| 18. 465X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN 11th 1965 to JAN 27th 1965, that (I) (we) last saw the deceased alive on JAN 27th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Kulikarmi | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Kulikarmi | | | | 23D. ADDRESS Women's Hospital Baltimore 17 MD U.S.A. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-29-65 | | 24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR JOHN O. MITCHELL & SONS, INC. 1900 EUTAW PLACE BALTO, MD. | | | |



BIRTH NO.

65 1054

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1054

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE MELVIN ANTHONY PRICE

2. DATE AND HOUR PRONOUNCED DEAD

January 28, 1965 2:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

416 N. Chester Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Aug. 22, 1920

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Plumber

10B. KIND OF BUSINESS OR INDUSTRY

H.B. Fosler & Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Price

14. MOTHER'S MAIDEN NAME

Mary A. Kernan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-18-9734

17. INFORMANT

ADDRESS

Anna M. Price 416 N. Chester Street #31

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gunshot Wound of Head.

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

416 N. Chester Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour) m. January 28 '65 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/28/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/1/65

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

N 853.4 JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
2801-03-05 E. Madison Street

ADDRESS

#5

WALTER A. PROFFER

WALTER A. PROFFER

FUNERAL DIRECTOR: IMPORTANT

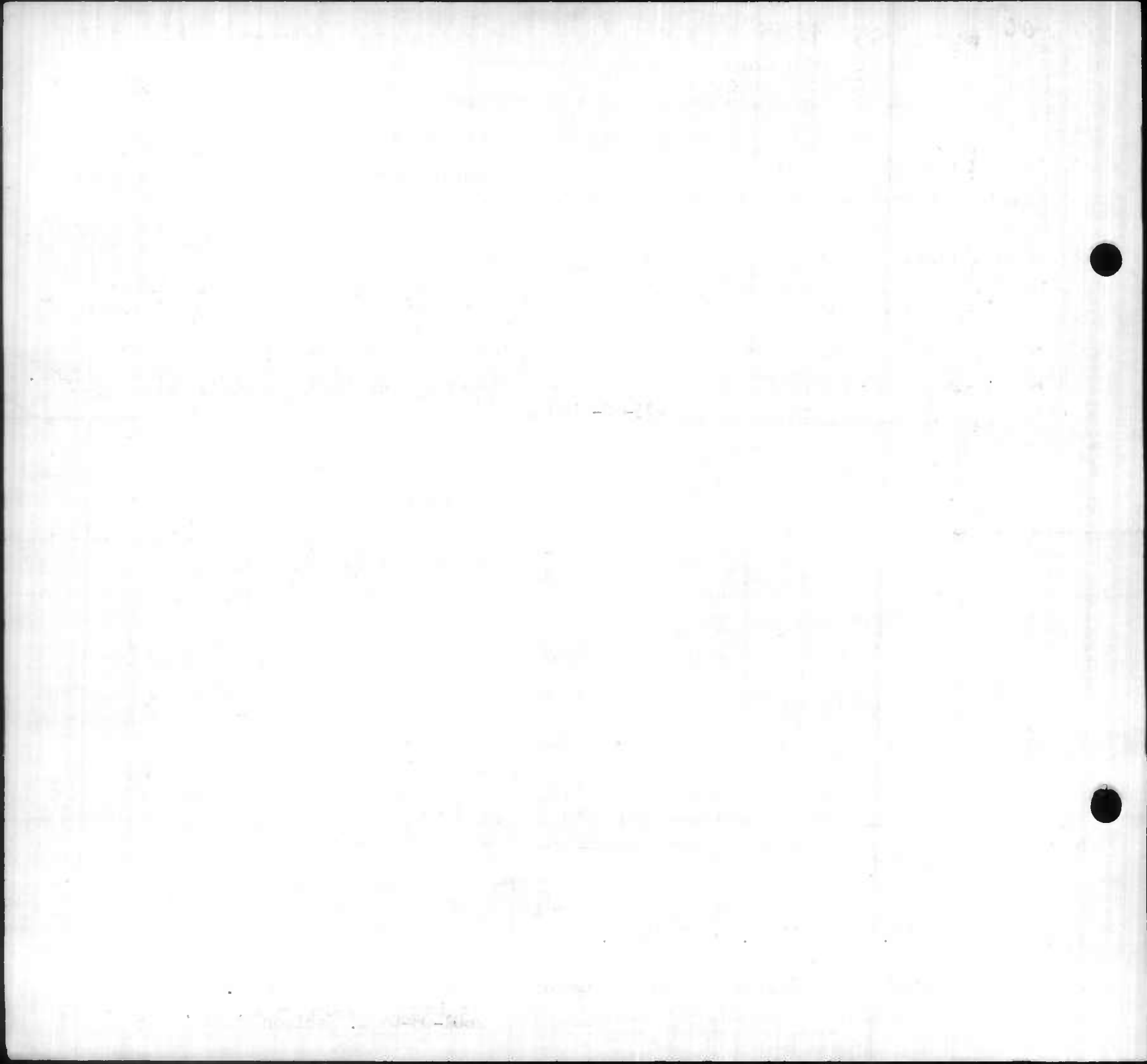
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W. 2001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1055

| | | | |
|--|------------------|---|------------------------------|
| BIRTH NO. 65 1055 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) JOHN WICK | | 2. DATE AND HOUR OF DEATH 1/27/65 12:40 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1606 HARTSDALE ROAD | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 12/23/86 |
| 9. AGE (In years last birthday) 78 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN CO. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM WICK | | 14. MOTHER'S MAIDEN NAME MARGARET (LAST NAME UNKNOWN) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-22-2169 A | |
| 17. INFORMANT Eileen Tochterman 1606 Hartsdale Road #12 HOSPITAL RECORDS | | 18. ADDRESS 1606 Hartsdale Road #12 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis @ parietal lobe ASUP | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary infarction | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 30 1964 to JANUARY 27 1965, that (I) (we) lost saw the deceased alive on JANUARY 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE William R. Linton, Jr. | | 23B. DATE SIGNED 1/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. WILLIAM R. LINTON, JR. | | 23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/65 | |
| 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR R. E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street | | 25D. ADDRESS #5 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| On Approval - M.E. BY DR. LINTHICUM | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 1056 | |
|--|-------------------------|--|---|---|---|--|--|
| BIRTH NO. 65 1056 | | | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) JOSEPH BLYER | | | | 2. DATE AND HOUR OF DEATH 1-28-65 4 15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-41 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3392 St. Benedict St. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH 5-10-82 | | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Thomas Blyer | | | 14. MOTHER'S MAIDEN NAME Frances | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 190035834 | | 17. INFORMANT ADDRESS HELEN Dowling 3392 St. Benedict St | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E904.0 I Staph pneumonia | | | CAUSE OF DEATH (A) DUE TO Staph pneumonia (B) DUE TO pneumonia (C) DUE TO Rib fracture | | INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks 4 weeks | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II EVA | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? 3392 Benedict St | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 3 65- 4 30 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell in bathroom | | 25-41 | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-8 19 65 to 1-28 19 65 , that (I) (we) lost saw the deceased alive on 1-28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Bruce Lee Evatt | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) BRUCE LEE EVATT | | | | 23D. ADDRESS Johns Hopkins Hopkins | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 1/29/65 | | 24C. NAME of CEMETERY or CREMATORY PUNXSUTAWNEY PENN | | 24D. LOCATION (City, town, or county) (State) 4101 Edmondson Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. N820 JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wittke | | ADDRESS 4101 Edmondson Ave | |

3 weeks
4 weeks

premature
kid fracture

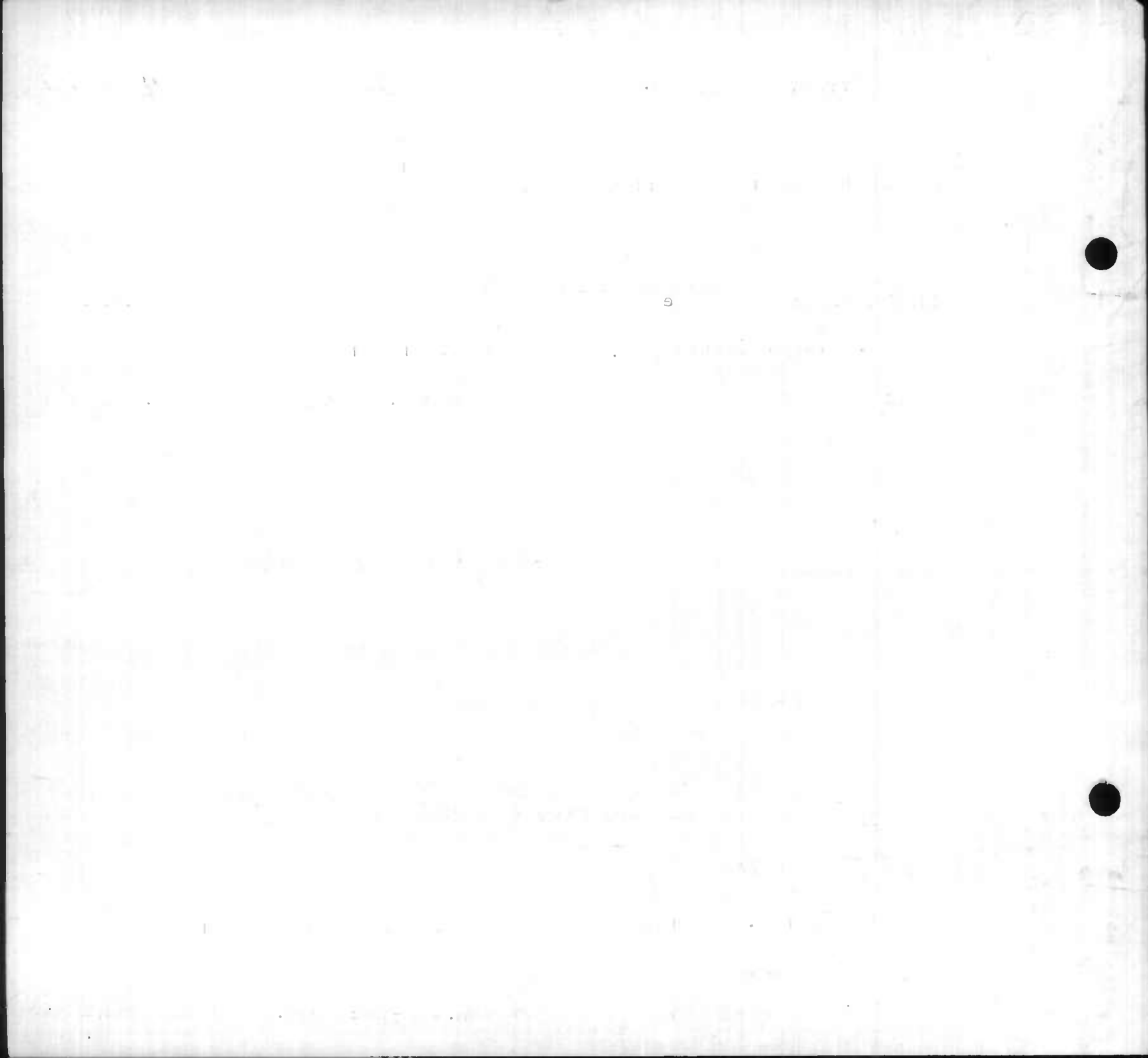
CVA

YES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) Accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

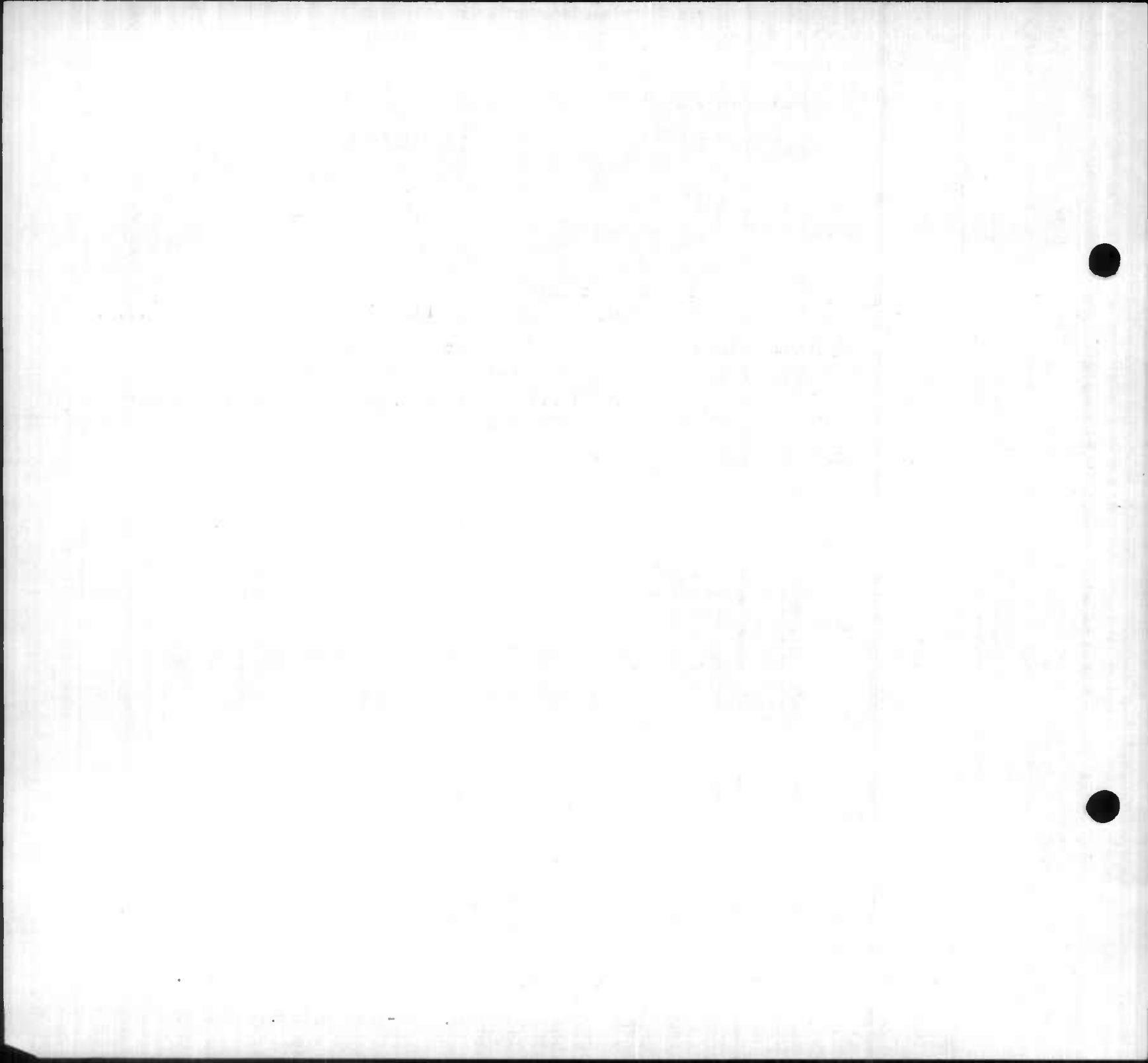
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1057 | |
|--|---------------------|---|--|---|---|
| BIRTH NO. 65 1057 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) HAROLD STUART COWLES, Jr. | | | 2. DATE AND HOUR OF DEATH JANUARY 28, 1965 10:15A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21204 D. STREET ADDRESS (If rural, give location) 310 ALABAMA RD | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11/22/28 | 9. AGE (In years last birthday) 36 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Manager | | 10B. KIND OF BUSINESS OR INDUSTRY American Greeting Card Corporation | | 11. BIRTHPLACE (State or foreign country) Hartford, Conn | |
| 13. FATHER'S NAME H. STUART COWLES, Sr., | | | 14. MOTHER'S MAIDEN NAME MARY FITZGIBBON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 042 20 5375 | | 17. INFORMANT ADDRESS Louise T. Cowles, 310 Alabama Rd., 21204 | |
| 18. 201 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Hodgkin's Disease | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 19 1964 to Jan. 28 1965 , that (I) <u>we</u> last saw the deceased alive on January 28 1965 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herbert J. Harwick | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Jan. 28, 1965 |
| 23C. PHYSICIAN'S NAME (Type) HERBERT J. HARWICK | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-1-65 | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. F... | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Townson, Inc., 1050 York Road, 21204 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

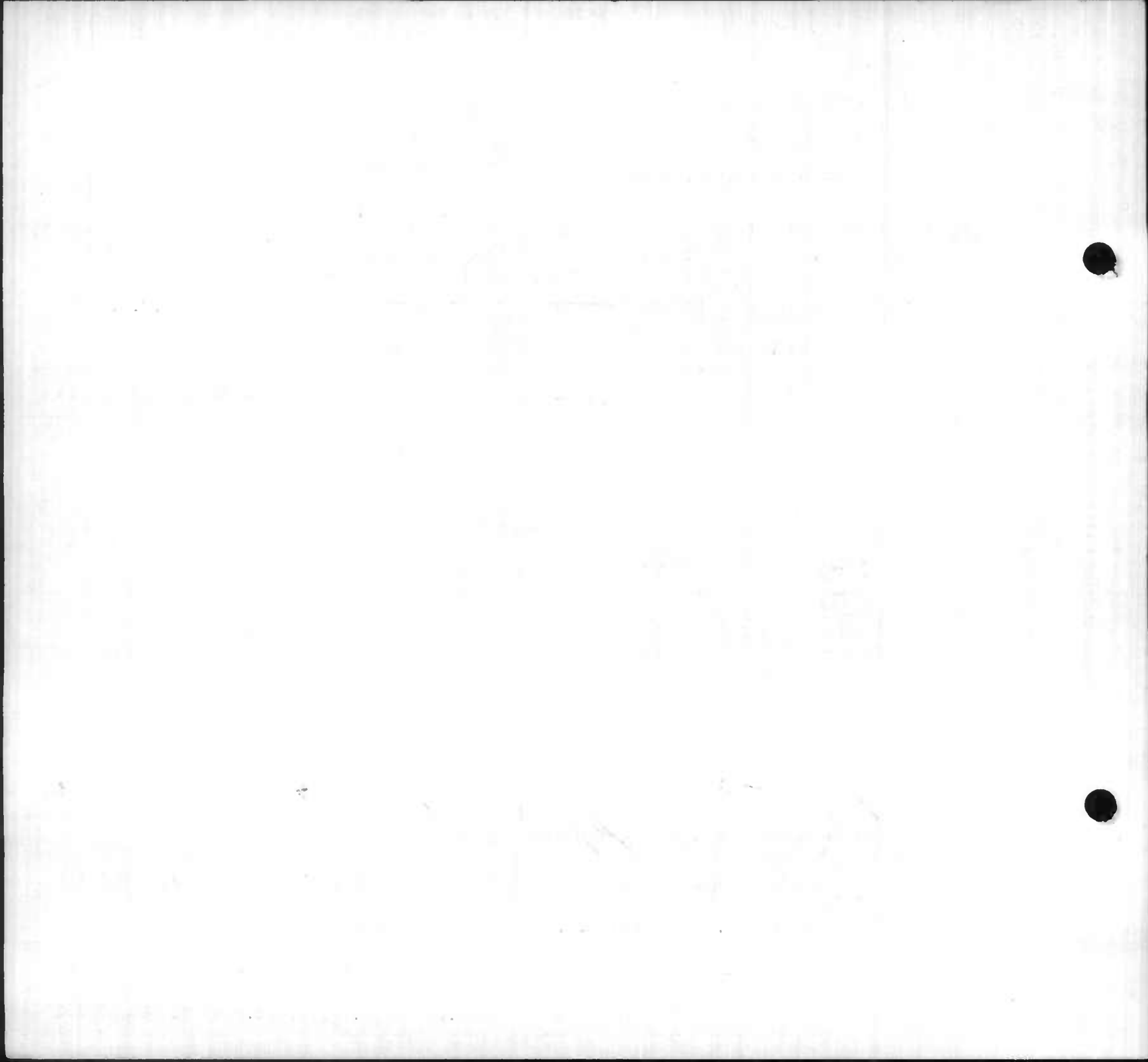
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | |
|--|-------------------------|---|--|---|--|--|--|---|---------|--|
| BIRTH NO. 65 1058 | | Registered No. 65 1058 | | | | | | | | |
| M.E. CASE NO. F | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) RALEIGH, ROBISON | | | | | 2. DATE AND HOUR OF DEATH 1/28/65 9:45 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-03 | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1204 WINDEMERE AVE. | | | | | |
| 5. SEX M | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH July 5, 1916 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician | | | 10B. KIND OF BUSINESS OR INDUSTRY New Deal Optical Company | | 11. BIRTHPLACE (State or foreign country) Ohio | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Tyrenus Robison | | | | | 14. MOTHER'S MAIDEN NAME Della Coffman | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 200 03 6933 | | 17. INFORMANT ADDRESS Luella M. Robison, 1304 Windemere Ave, 21218 | | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/6 19 65 to 1/28 19 65 , that (I) (we) last saw the deceased alive on 1/28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE R. F. Balogh | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1/28/65 | | |
| 23C. PHYSICIAN'S NAME (Type) DR. LEONARD ACKMAN | | | | | 23D. ADDRESS SINAI HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-1-65 | | 24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Gardens | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR Wm. Cook-Towson, Inc., 1050 York Road, 21204 | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1059 | |
|--|---|---|---|---|---|
| BIRTH NO. 65 1059 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) William Gebo | | 2. DATE AND HOUR OF DEATH January 28, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214 D. STREET ADDRESS (If rural, give location) 1702 Northbourne Road | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH May 12, 1885 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10B. KIND OF BUSINESS OR INDUSTRY Maintenance man | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Joseph Gebo | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 127-01-8075 | | 17. INFORMANT ADDRESS Donald Gebo, 1702 Northbourne Road 21214 | |
| 18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1/28/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cor Pulmonale | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Chr. Pulmonary Emphysema | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Jan 1 1965 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 64 to Jan 28 1965 , that (I) (we) last saw the deceased alive on Jan 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edward L. Glassman M.D. | | | | 23B. DATE SIGNED 1/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) Edward L. Glassman, M.D. | | | | 23D. ADDRESS 4037 Falls Road, Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 1-28-65 | | 24C. NAME OF CEMETERY or CREMATORY Churchville, New York | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202 | |



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)F.
GEORGE AMSEL

2. DATE AND HOUR PRONOUNCED DEAD

January 25, 1965 10:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

22 N. Chester Street

5. SEX
Male6. RACE
White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

Dec. 26, 1938

9. AGE (In years
last birthday)

26 XX

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Penitentiary

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Edward Amsel

14. MOTHER'S MAIDEN NAME

Helen (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Kay Rosalie Amsel, 327 S. Chester Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22 N. Chester Street

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

1 25 65 9:55 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-28-65

23C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

23D. LOCATION

(City, town, or county)

Glen Burnie Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 29 1965

Robert E. Taylor, M.D.

Wm. Cook, Inc., 1217 St. Paul Street, 21202

WALTER POLK

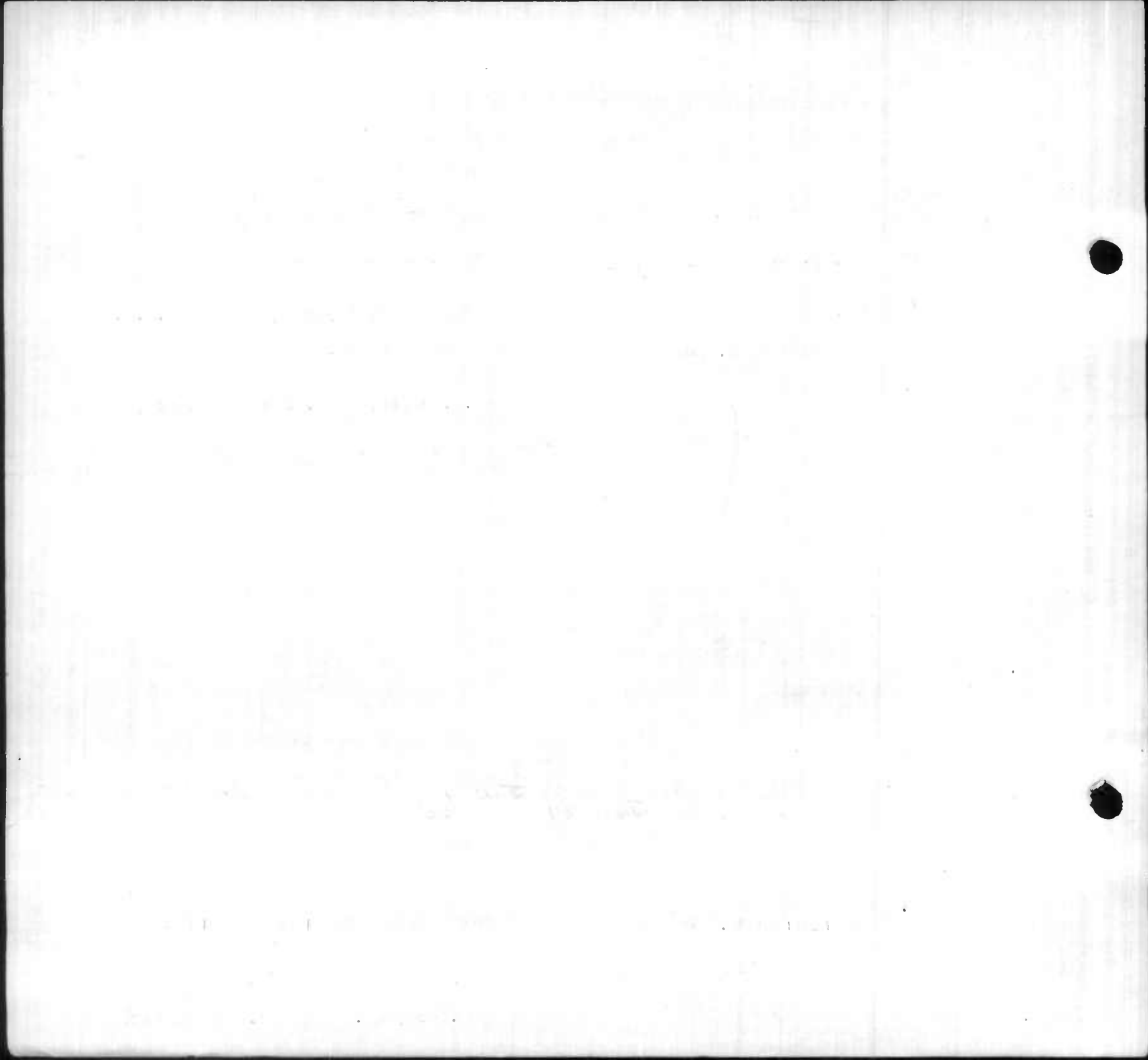
MACDONALD

1921

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1061 | |
|--|-------------------------|---|---------------------------------------|---|---|
| BIRTH NO. 65 1061 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Nuffer, Dorothy M.</i> | | 2. DATE AND HOUR OF DEATH <i>27 JAN 65 8:00 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>23-02</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hosp</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 30</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>38 E Wheeling St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>12-16-1910</i> | 9. AGE (in years last birthday) <i>54</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 13. FATHER'S NAME <i>William E. Nuffer</i> | | 14. MOTHER'S MAIDEN NAME <i>Agnes McDonough</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Wm. E. Nuffer, 38 E. Wheeling Street, 21230</i> | |
| 18. I <i>170X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>Co (R) breast c metastasis</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>7mo</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes for No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>JAN 4</i> 19 <i>65</i> to <i>JAN 27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>JAN 27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William E. Grose</i> M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>WILLIAM E. GROSE</i> | | | | 23D. ADDRESS M.D. <i>THE JOHNS HOPKINS HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1-30-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Wm. COok, Inc., 1217 St. Paul Street, 21202</i> | |



1
C-100

65 1062

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1062

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MINNIE COFFEY

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1965

7:00 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 11-01

D. STREET ADDRESS (If rural, give location)

938 N. Calvert St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Oct. 22, 1939

9. AGE (In years
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Castle

14. MOTHER'S MAIDEN NAME

Ketha Leach

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ketha Castle, Mount Sterling, Kentucky

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHE 823.4 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Baltimore Washington Expressway

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 27 65 6:00a

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver ran into bridge abutment

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVAL

23B. DATE

1-28-65

23C. NAME of CEMETERY or CREMATORY

Martin Cemetery

23D. LOCATION

(City, town, or county)

Montgomery County, Kentucky

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

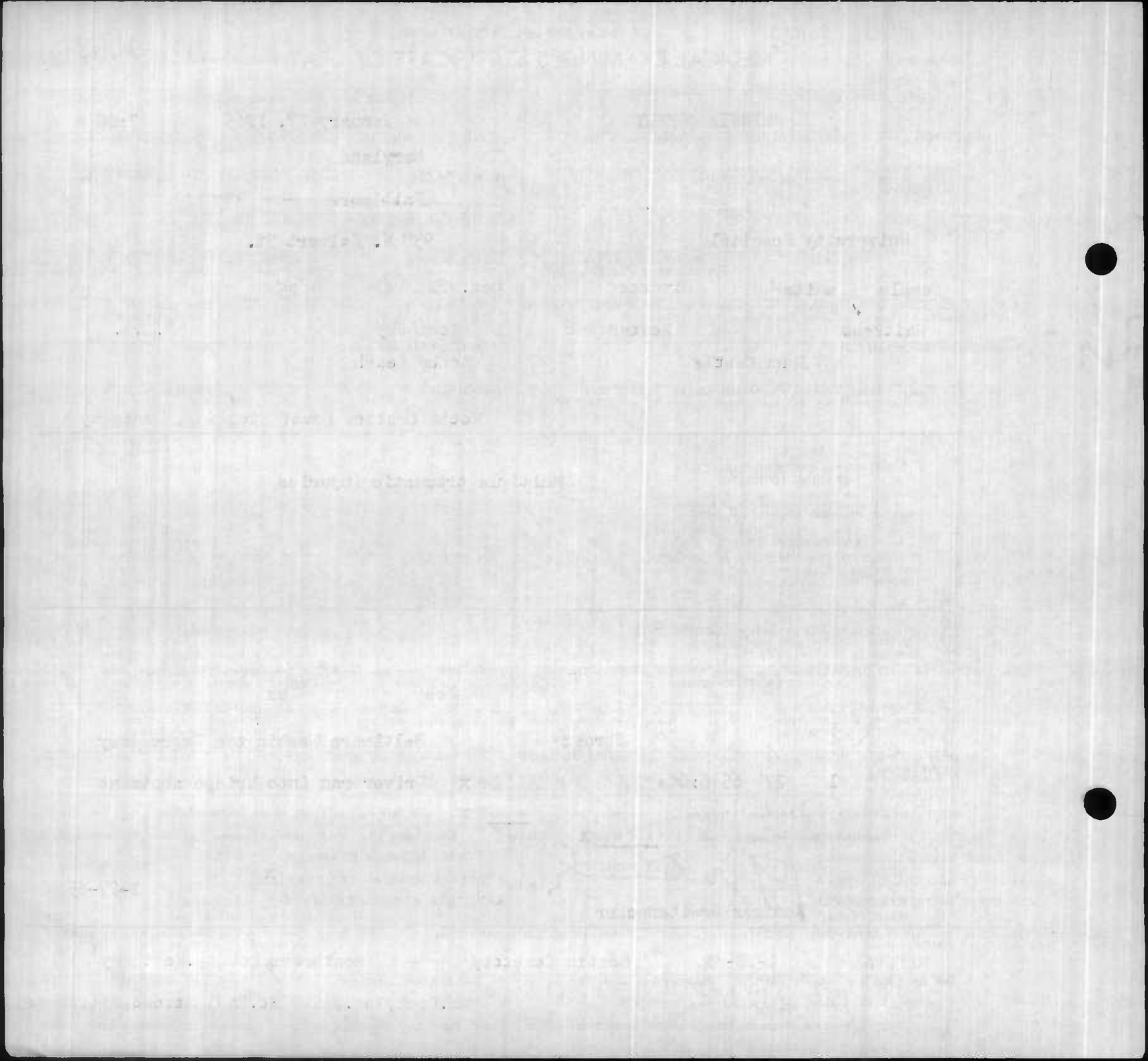
24B. NAME OF REGISTRAR

Robert E. Jarboe

24C. FUNERAL DIRECTOR

Wm. Cook, Inc., 1217 St. Paul Street, Baltimore

ADDRESS



1

65 1063

BALTIMORE CITY HEALTH DEPARTMENT

65 1063

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

R.

WENDALL HAY

2. DATE AND HOUR PRONOUNCED DEAD

January 26, 1965

3:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2718 Reese St., Waverly Apts.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single

8. DATE OF BIRTH

Aug. 11, 1920

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Automobile

11. BIRTHPLACE (State or foreign country)

Johnstown, Pa

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Walter Hay

14. MOTHER'S MAIDEN NAME

Viola Brubaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

159-14-7445

17. INFORMANT

ADDRESS

Allen Hostetler. 143 3rd Ave. Baltimore 21227

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVAL

23B. DATE

1-26-65

23C. NAME of CEMETERY or CREMATORY

Jenners Cross Roads

23D. LOCATION

(City, town, or county)

(State)

Boswell

Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

JAN 29 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul Street, 21202

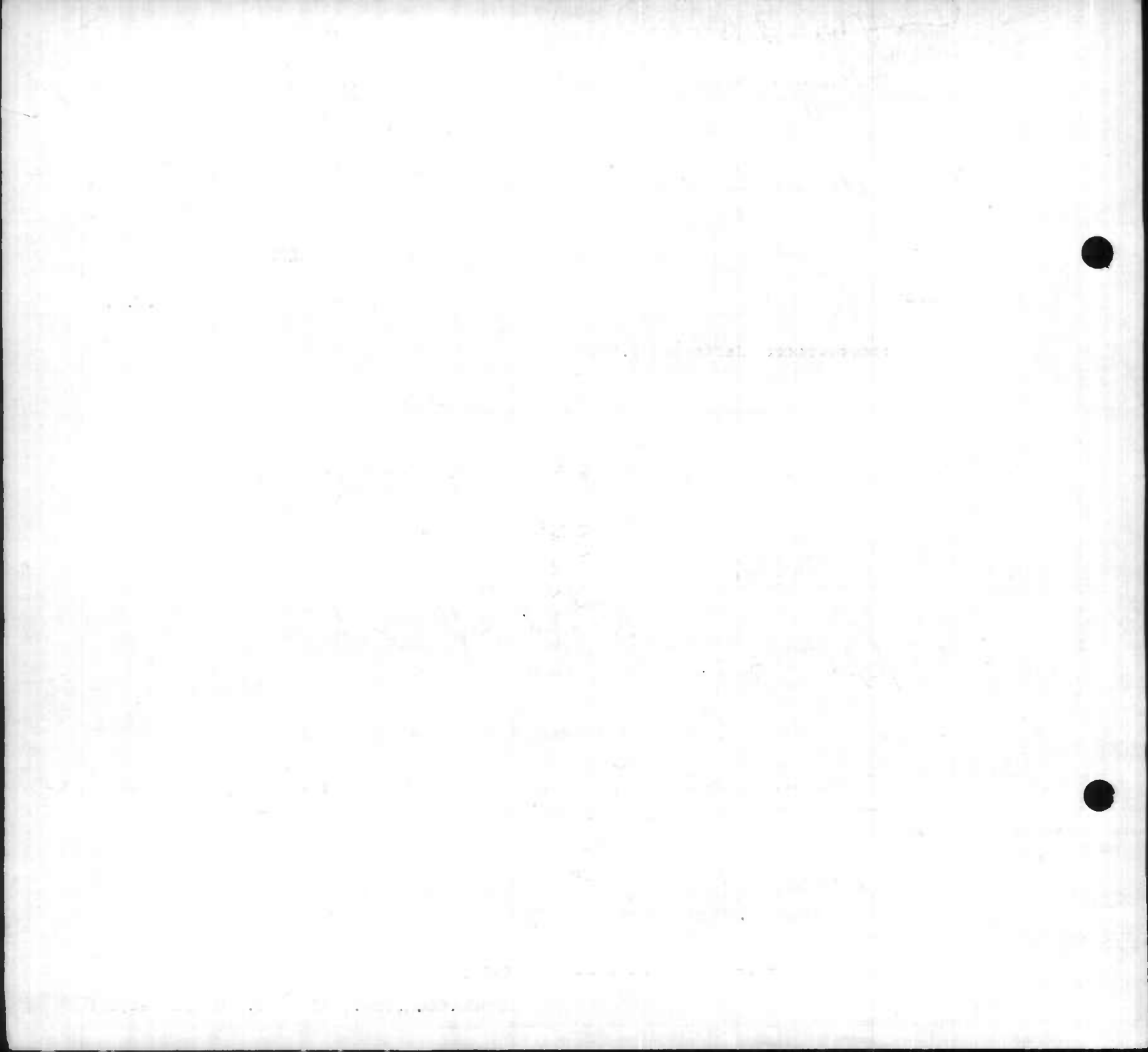
WANT NEW RECORDS

FRANCIS J. CONLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

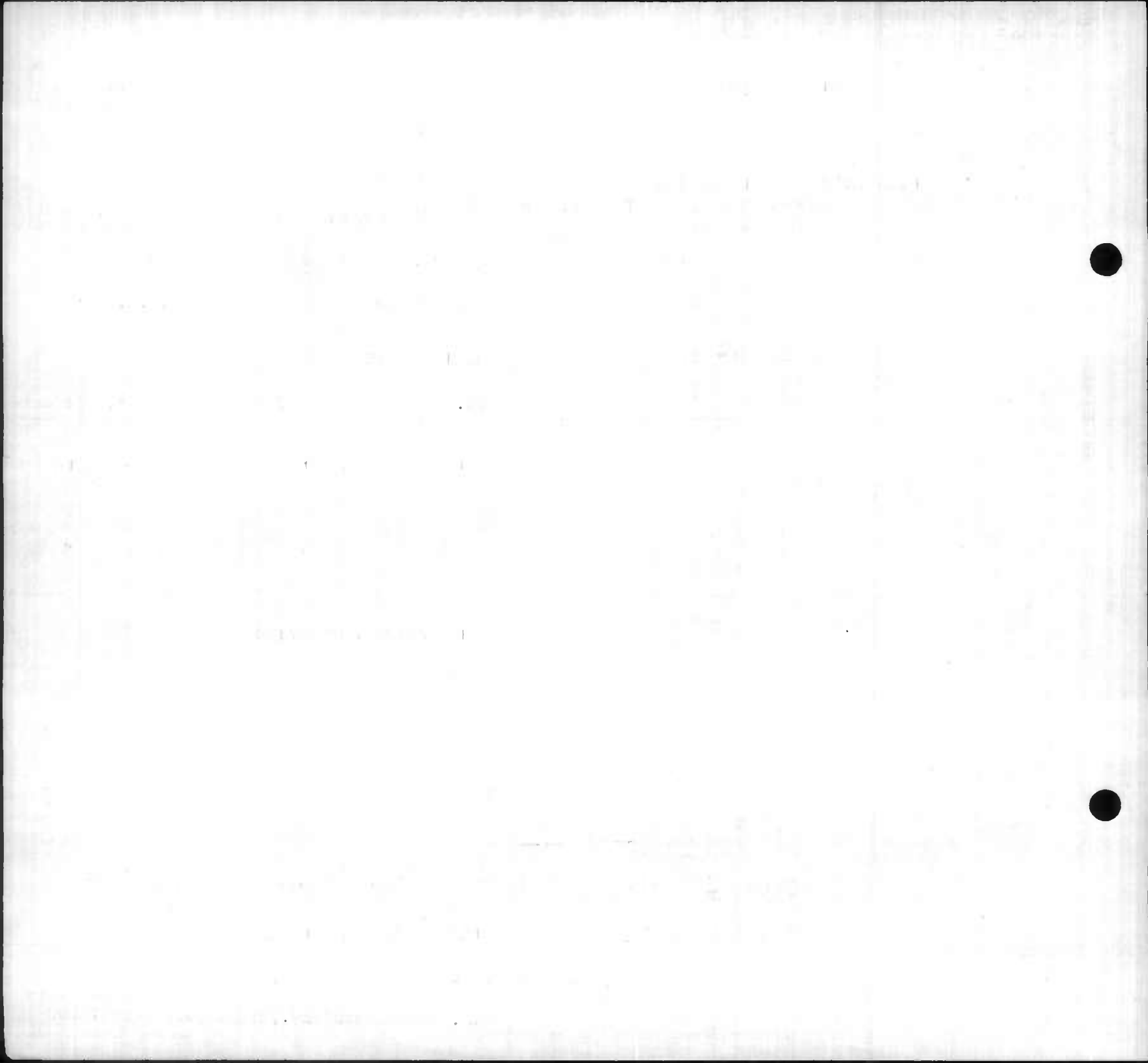
| For approval by Medical Examiner | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1064 | |
|--|--|--|--|---|--|--|--|---------------------------------------|--|
| BIRTH NO. 65 1064 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mary Ann Ewing | | 2. DATE AND HOUR OF DEATH 1/23/65 9:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 46 | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 1/4/95 | | 9. AGE (In years last birthday) 70 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Harold Jefferson T. Slorp | | | | 14. MOTHER'S MAIDEN NAME unknown Raggle | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Self | | ADDRESS | | | |
| 18. 545X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. CAUSE OF DEATH Infected & leaking abdominal aortic (tylon) graft. Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Infected graft 2° to fistula | | | | | | | |
| 19A. DATE OF OPERATION 1/13/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal aortic fistula | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan - 11 1965 to Jan. 23 1965, that (I) (we) last saw the deceased alive on Jan 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Bruce H. MacPherson M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/23/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Bruce H. MacPherson M.D. | | | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Westminster Cemetery | | 24D. LOCATION (City, town, or county) Westminster, Md | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 Robert E. Farker, M.D. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, 21202 | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

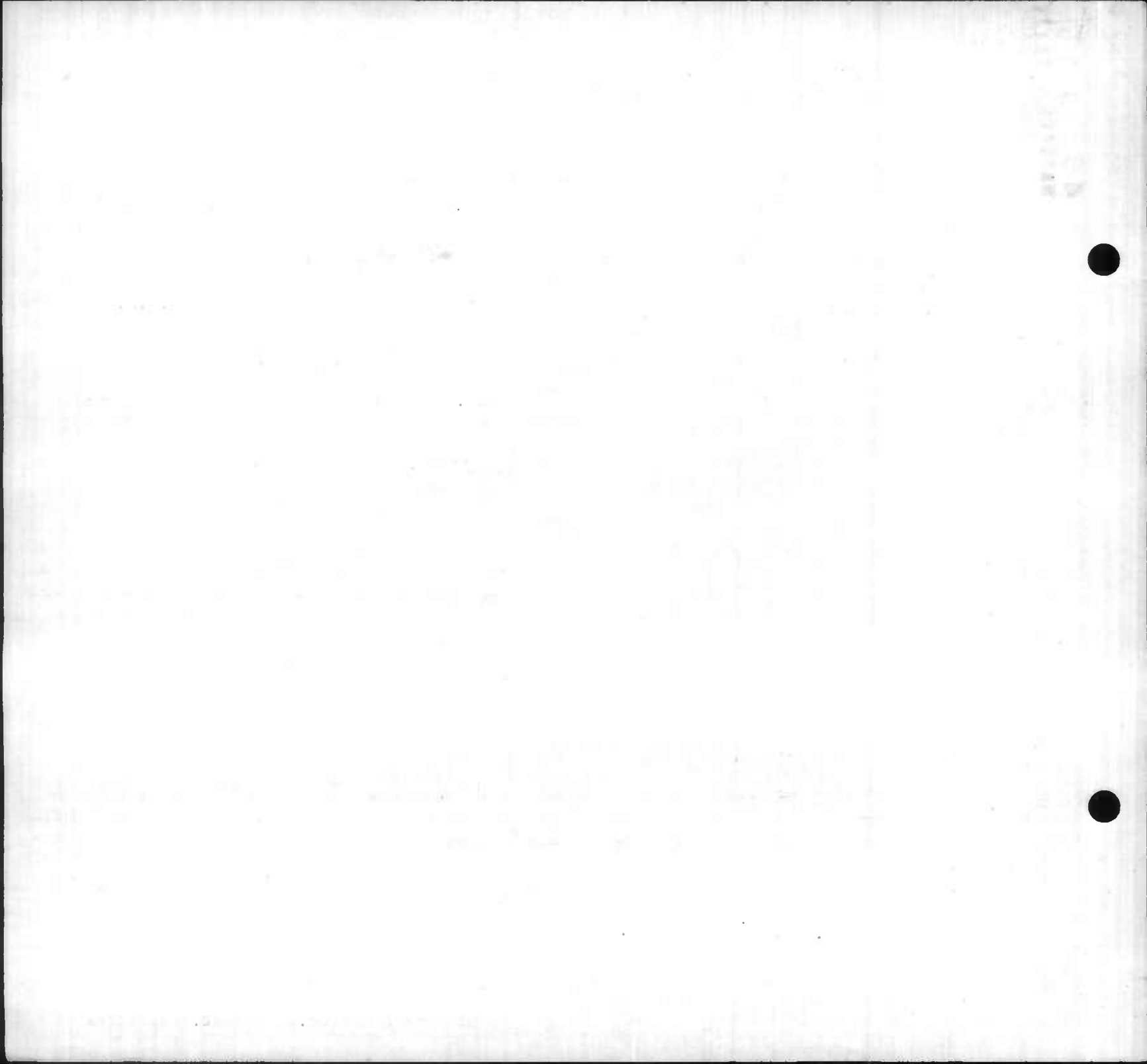
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1065 | |
|---|--------------|---|-----------------------------|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 65 1065 | |
| BIRTH NO. 64-10772 1065 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) LOIS M GAMBER | | | | 1/25/65 11:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHILDREN'S HOSPITAL INC 3825 GREENSPRING AVE BALTO 11, MD | | A. STATE MARYLAND | | B. COUNTY 27-18 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 3707 ARCADIA AVE | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 4/20/64 | 9. AGE (In years last birthday) 9 5 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME JACK GAMBER | | 14. MOTHER'S MAIDEN NAME LOIS NALE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Lois Gamber, 3707 Arcadia Avenue, Baltimore | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 754.5 I CONGENITAL HEART DISEASE BIRTH-DEATH | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. UPPER RESPIRATORY INFECTION | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT 16 1964 to JAN 25 1965, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harvey L. Levy | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) HARVEY L LEVY | | 23D. ADDRESS M.D. CHILDREN'S HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Calvary Providence Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Gamber, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Townson, Inc., 1050 York Road, 21202 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1066</u> | |
|--|-----------------------------|---|---|--|--|
| BIRTH NO. <u>65 1066</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Elizabeth Hassett</u> | | 2. DATE AND HOUR OF DEATH <u>1-27-65</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>7-03</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 5</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>908 - N. Humeau</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widow</u> | 8. DATE OF BIRTH <u>9-8-85</u> | 9. AGE (In years last birthday) <u>85</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>John W. Crosby</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Wright</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. Margaret Wilson, 2600 Maryland Avenue</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Conjunctive Heart Failure?</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) DUE TO | | | |
| | | (B) DUE TO <u>Myocardial Infarction</u> | | | |
| | | (C) <u>ASCVD</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>✓</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (we hospital) attended the deceased from <u>1/26/65 2PM</u> 19 <u>65</u> to <u>2:30AM</u> <u>1/27</u> 19 <u>65</u> that (I) (we) lost saw the deceased olive on <u>1/27/65 2:30AM</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Michael Lesch</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/27/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. MICHAEL LESCH.</u> | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>1-20-65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sabin</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>William COok, Inc., 1217 St. Paul Street</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|-------------------------|--|--|---|--|--|---|--|---|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1067 | | | | | | |
| BIRTH NO. 65 1067 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary McGrath Gilson</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Jan 25, 1965 3:50 A</i> M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i> | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Towson 4</i> | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>AGED Women's & Men 615 Chestnut</i> | | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Cauc.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>12-15-80</i> | 9. AGE (In years last birthday) <i>84</i> | If Under 1 Yr. Months: Days: Hours: Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <i>Michigan</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | |
| 13. FATHER'S NAME <i>John W. McGrath</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Lillie Walker</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Son Ed. M. Gilson</i> | | | ADDRESS <i>4424 Marblehall</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>170x I Mitral stenosis causing @ heart to lungs</i> | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | | | | |
| | | | | | (B) DUE TO | | | | | | |
| | | | | | (C) DUE TO | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 4, 1965</i> to <i>Jan 25, 1965</i> , that (I) (we) last saw the deceased alive on <i>Jan 24, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Charles L. Fletcher</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>Jan 25, 1965</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>CHARLES L. FLETCHER</i> | | | | | 23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1-28-65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Parsons Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Salisbury, Maryland</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>Wm. Cook, Inc.,</i> | | | ADDRESS <i>1217 St. Paul Street, 21202</i> | | |

CHART 2. L. FLIGHT

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. 65 1068

M.E. CASE NO. _____

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Thomas (Freeze) Szczukowski</u> | | 2. DATE AND HOUR PRONOUNCED DEAD <u>Jan. 30, 1965</u> <u>2:05 A</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>2601</u> D. STREET ADDRESS (If rural, give location) <u>4609 Hazelwood Road</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Dec. 10, 1906</u> |
| 9. AGE (In years last birthday) <u>58</u> | | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoot set up</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>National Can. Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltor Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>W. S. A.</u> | |
| 13. FATHER'S NAME <u>Apolinaris Szczukowski</u> | | 14. MOTHER'S MAIDEN NAME <u>Susanna Fryza</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>216-01-4750</u> | |
| 17. INFORMANT <u>Mary Szczukowski</u> | | ADDRESS <u>Box 589 - 25 Md.</u> <u>Sharon Drive Glenarm</u> | |

| | | | |
|-----------------------|--|--|----------------------------------|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH <u>422.1 + 322.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) DUE TO _____ (B) DUE TO _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH |
| | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Acute ethylism | | |
| | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John E. Adams M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED Jan. 30, 1965

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 23A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23B. DATE <u>2/3/65</u> | | 23C. NAME of CEMETERY or CREMATORY <u>Holy Cross</u> | | 23D. LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u> | |
| 24A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 24B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> | | 24C. FUNERAL DIRECTOR <u>Wm. S. Fialkowski</u> | | ADDRESS <u>2007 Eastern ave</u> | |

WALLING FOLIO

WASHINGTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1069 | |
|--|---------------------|---|---|---|---|
| BIRTH NO. 65 1069 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Michael L. Hawkins</u> | | | 2. DATE AND HOUR OF DEATH <u>29 Jan 65</u> <u>3 58</u> P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>25-05</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1610 Church St.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>5-6-07</u> | 9. AGE (In years last birthday) <u>57</u> | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe fitter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>US Coast Guard</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Amos Hawkins</u> | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Wolfe</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>212-07-7348</u> | | |
| 17. INFORMANT <u>Mary Hawkins</u> <u>Wife</u> | | | 18. ADDRESS <u>1610 Church St</u> <u>Same as above</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> A — <u>MASSIVE Cerebral Infarction</u> B — <u>Carotid artery thrombosis</u> C — <u>Carotid artery embolus</u> D — <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION <u>27 Jan 65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carotid Artery Thrombosis</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>21 Jan 1965</u> to <u>29 Jan 1965</u> , that (I) (we) last saw the deceased alive on <u>29 Jan 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jesse A. Marcel</u> | | | | 23B. DATE SIGNED <u>29 Jan 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jesse A. Marcel</u> | | | | 23D. ADDRESS M.D. <u>c/o MGH</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-2-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>A.A. Co. Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Farkas</u> | | 25C. FUNERAL DIRECTOR <u>Wm. J. Zalkowski</u> | | | |
| 25D. ADDRESS <u>2007 Eastern Ave</u> | | | | | |

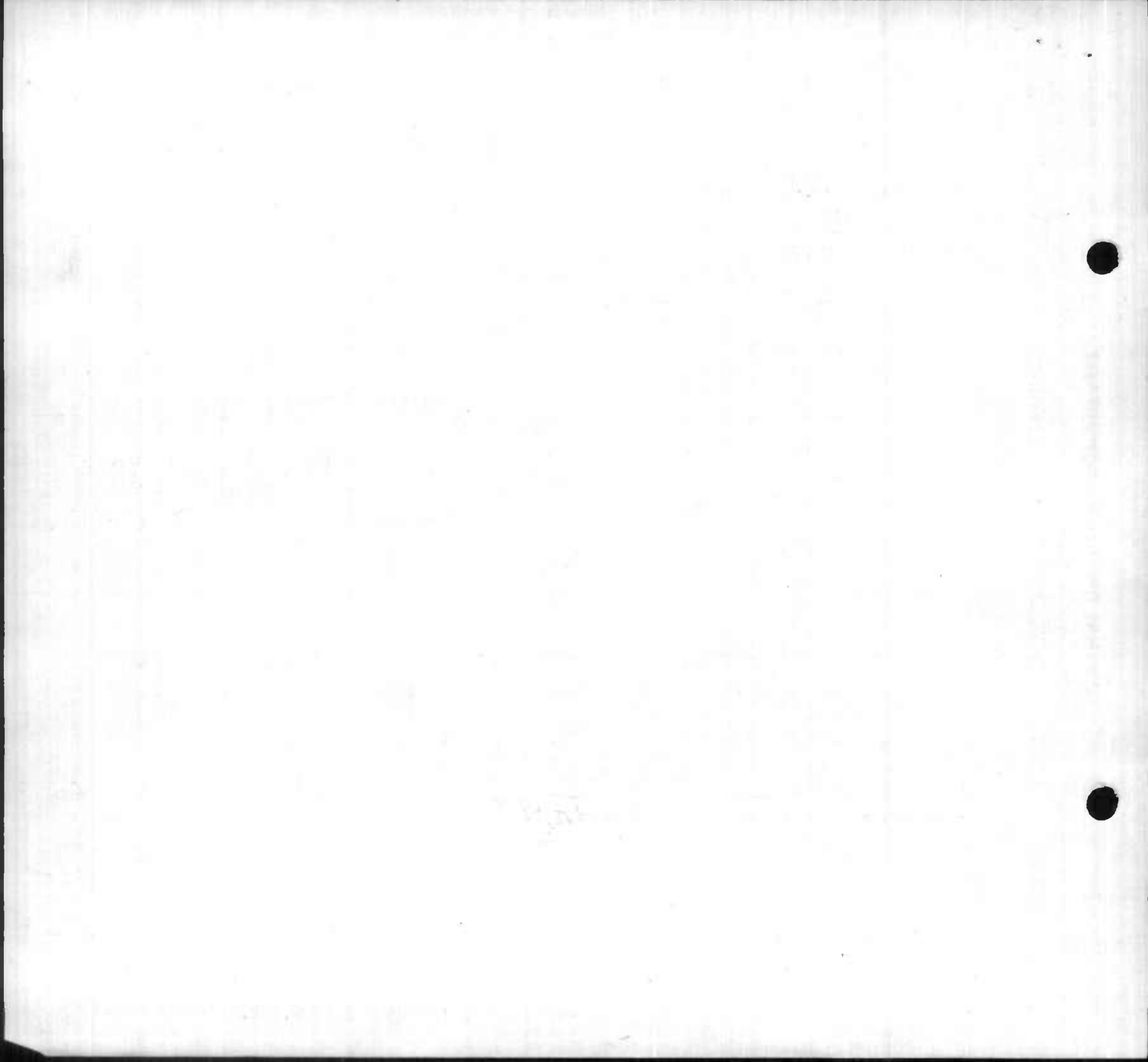
12-1-1911
The following is a list of the
names of the persons who
were present at the
meeting of the
Board of Directors
of the
Company held on
the 12th day of
January 1911.

John A. Mearns
President

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|---|---|--|---|-------------------------------------|------------------------|--|
| BIRTH NO. 65 1070 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 1070 | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) IRENE TRAUB SNYDER | | | | | JANUARY 28, 1965 8 A. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ESPLANADE APARTMENTS APT 2F 2519-2525 EUTAW PLACE #17 | | | | | A. STATE MARYLAND B. COUNTY 13-01 | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | D. STREET ADDRESS (If rural, give location) 2519-2525 EUTAW PLACE APT 2F | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/19/1903 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME JACOB TRAUB | | | | | 14. MOTHER'S MAIDEN NAME MINNIE ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MR. WILLIAM HOFFENBERG TITLE BUILDING | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X I CAUSE OF DEATH (A) Carcinoma of breast (B) Metastatic carcinoma of breast (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 years 3 months | | | | | | | | | |
| 19. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from September 19 64 to 28 Jan 1965, that (I) (we) last saw the deceased alive on 25 Jan 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Louis P. Hamburger Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 28 Jan 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) Louis P. Hamburger Jr. | | | | | 23D. ADDRESS M.D. 1006 St Paul St. - Baltimore Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 1/30/65 | | 24C. NAME OF CEMETERY or CREMATORY MT. SINAI | | 24D. LOCATION (City, town, or county) (State) PHILADELPHIA, PENNSYLVANIA | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1071 | |
|---|---|---|--|--|---|--|--|
| BIRTH NO. 65 1071 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Levin, Frank. | | 2. DATE AND HOUR OF DEATH 1-28-65 11:55 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, MD D. STREET ADDRESS (If rural, give location) 2228 Walbrook Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 8-27-97 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed | | 10B. KIND OF BUSINESS OR INDUSTRY Upholstery | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Simon Levin | | | | 14. MOTHER'S MAIDEN NAME Anna Reba | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MRS. JEANNETTE LEVIN 2228 WALBROOK AVE | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) C. V. A. DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-27-1965 to 1-28-1965 , that (I) (we) last saw the deceased alive on 1-28-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. Gerami M.D. | | | | | | 23B. DATE SIGNED 1-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) S. Gerami | | | | 23D. ADDRESS M.D. Lutheran Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/29/65 | | 24C. NAME of CEMETERY or CREMATORY ANSHE EMUNAH AITZ CHAIM | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

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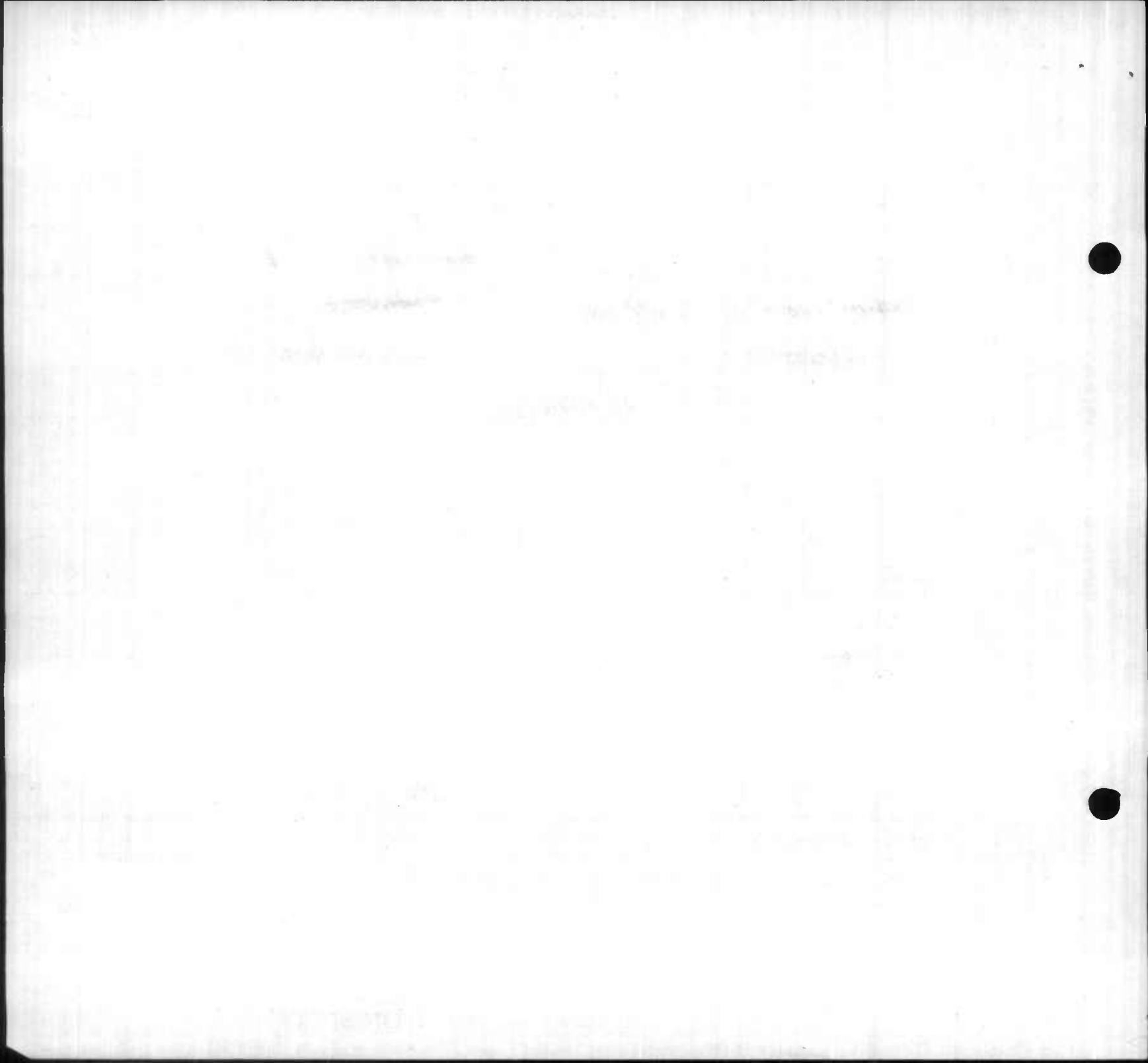
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1072</u> | |
|--|-------------------------|--|--|---|--|--|--|
| BIRTH NO. <u>65 1072</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>UTMAN, ISADORE (ISIDORE) ISIDOR</u> | | 2. DATE AND HOUR OF DEATH <u>1/27/65</u> <u>1 45</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u> | | | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>15-13</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| D. STREET ADDRESS (If rural, give location) <u>4214 PIMLICO ROAD # 15</u> | | | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated</u> | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) <u>65</u> | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURRIER</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u> | | 11. PLACE OF BIRTH or foreign country <u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Joseph UTMAN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>PEARL Nathan</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | 16. SOCIAL SECURITY NO. <u>216-07-0889</u> | | 17. INFORMANT <u>Hospital Record</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | |
| | | | | (B) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | |
| | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that he (this hospital) attended the deceased from <u>1/09/1965</u> to <u>1/27</u> 19 <u>65</u> , that he (we) last saw the deceased alive on <u>1/25</u> 19 <u>65</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Barry M. Cohen</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/27/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>BARRY M. COHEN</u> | | | | 23D. ADDRESS <u>Sinai Hospital</u> M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1/29/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>FORBAND</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u> | | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u> <u>6070 REISTERSTOWN ROAD</u> | | | |

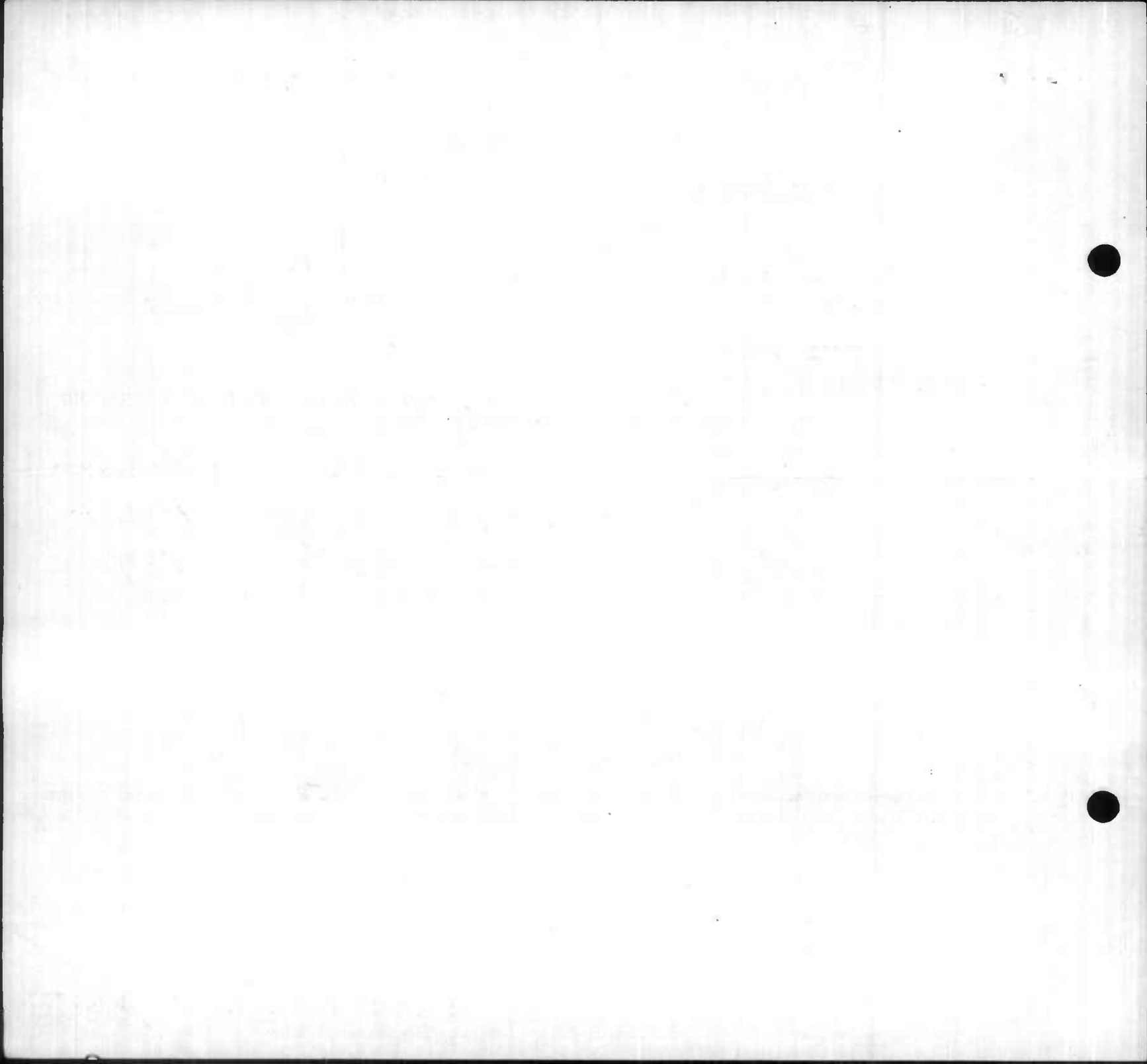


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

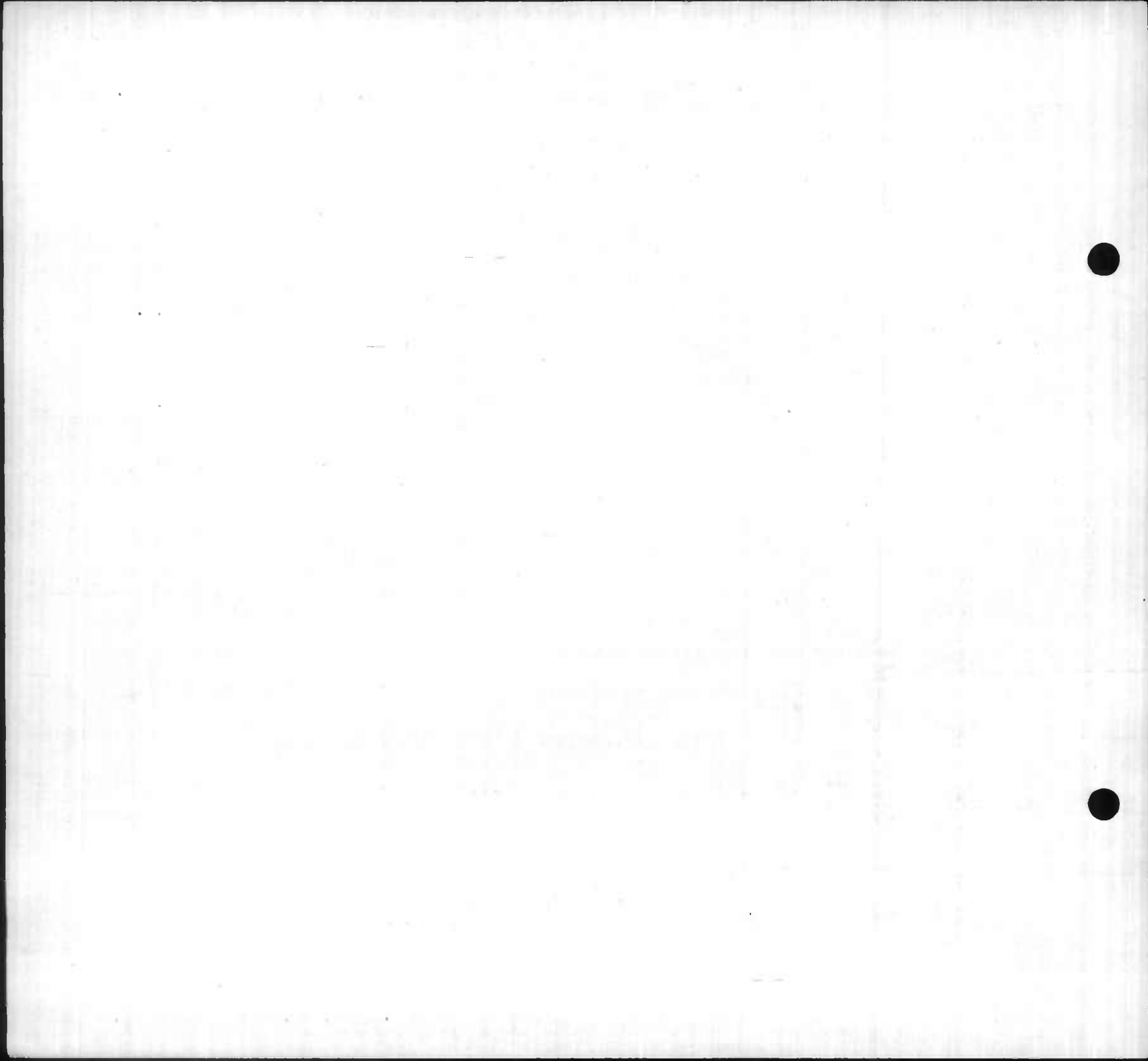
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1073 | |
|---|---|---|---|---|---|---|--|
| BIRTH NO. 65 1073 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) REBECCA GOLDMAN | | 2. DATE AND HOUR OF DEATH JANUARY 27, 1965 10:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4921 QUEENSBERRY AVENUE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 77 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ISAAC OFSKY | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT ADDRESS MR. ABRAHAM GOLDMAN 4921 QUEENSBERRY AVE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Acute coronary DUE TO | | Sudden | |
| | | | | (B) MASCUD DUE TO | | 10 yrs + | |
| | | | | (C) Diabetes mellitus DUE TO | | 20 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 20 19 52 to January 27 19 65 that (I) was last saw the deceased alive on Jan 27 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph C. Matchar M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH C. MATCHAR M.D. | | | | 23D. ADDRESS 6821 REISTERSTOWN Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/29/65 | | 24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

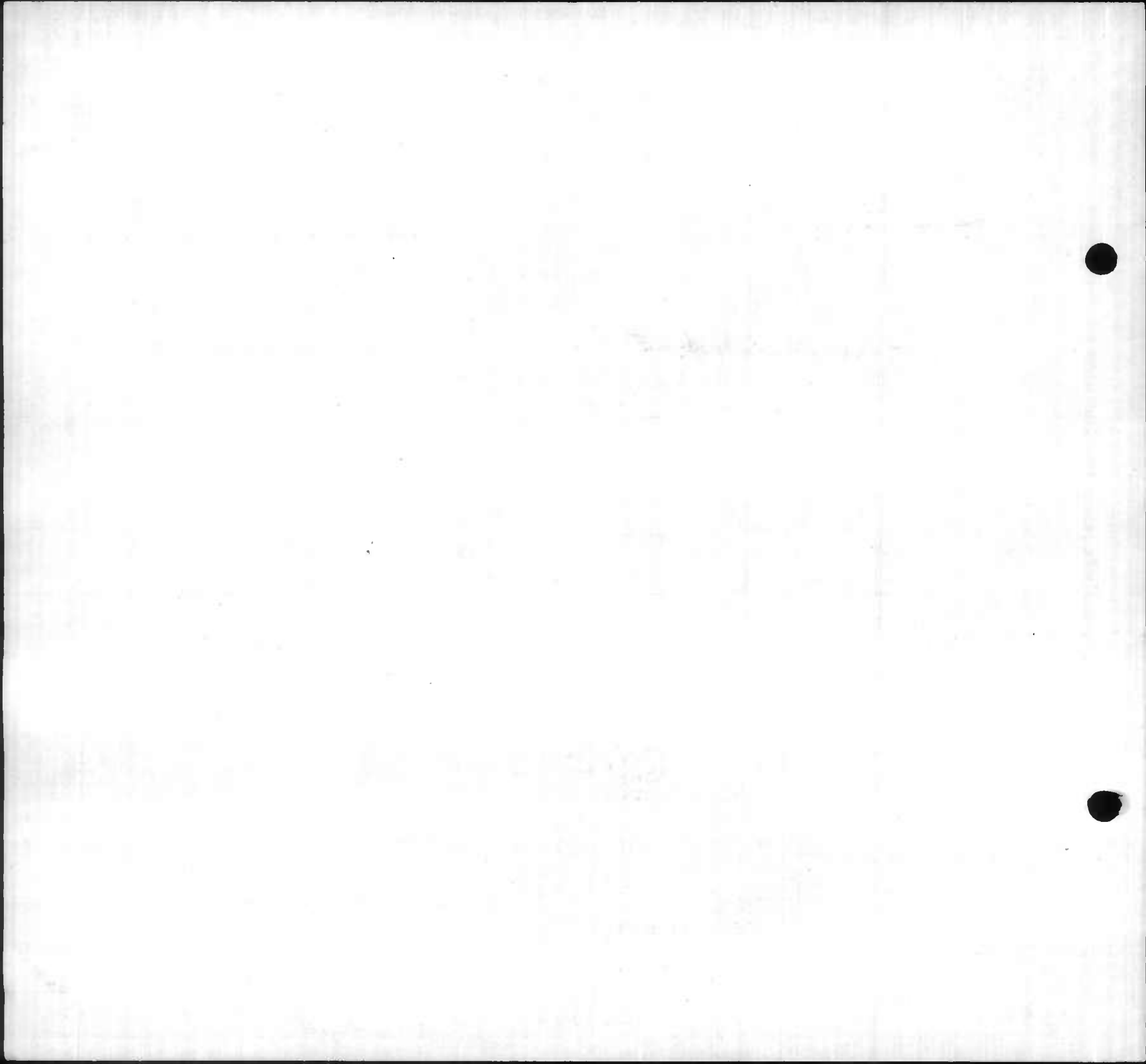
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|--|---|--|--|--|--|--|---------|
| BIRTH NO. 65 1074 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 1074 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Morton A. Gamsey</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Jan. 30, 1965</i> 1 <i>3.45 A</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1602 Hollins St.</i> | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Wh</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3-31-1888</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner</i> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Gamsey</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>—</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> <i>No. 1</i> | | | 16. SOCIAL SECURITY NO. <i>227 16 4259</i> | | 17. INFORMANT <i>Mrs. Edith Gamsey, 1602 Hollins St.</i> | | | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>154x I Acute Coronary Thrombosis</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(B) ?</i> <i>(C) Carcinoma rectum</i> | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1963</i> 19 to <i>Jan 30</i> 1965, that (I) (we) last saw the deceased alive on <i>Jan 30</i> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Morris D. Schreiber</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <i>1-30-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MORRIS D. SCHREIBER</i> | | | | | 23D. ADDRESS M.D. <i>1519 W. Lombard St.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-2-1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cem.</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>Thomas J. Kenny, Inc. 1600 Hollins St.</i> | | | ADDRESS |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1075 | |
|---|---------------------|---|--|--|--|--|--|--|------------------------------------|---|--|
| BIRTH NO. 65 1075 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) WILMORE, JAMES | | | | | | 2. DATE AND HOUR OF DEATH JAN. 29, 1965 11:48P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital | | | | | | A. STATE MARYLAND | | | | | |
| | | | | | | B. COUNTY 12-05 | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 1602 BARCLAY ST | | | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH 7/27/07 | | 9. AGE (In years last birthday) 59 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER | | | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL | | 11. BIRTHPLACE (State or foreign country) SO. CAROLINA | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENRY WILMORE | | | | | | 14. MOTHER'S MAIDEN NAME DAISY ? HENRYSON | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) not known | | | | 16. SOCIAL SECURITY NO. 218-09-6824 | | 17. INFORMANT ELIZA WILMORE | | | | ADDRESS 1602 Barclay St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH (A) Arteriosclerosis of Heart Dissect (B) _____ (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 7 | |
| | | | | | | Cerebral Thrombosis | | | | 2 mos. | |
| | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1 19 65 to Jan 29 19 65 , that (I) (we) lost saw the deceased alive on Jan 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Reubin C. Guerrero M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 1/29/65 | | |
| 23C. PHYSICIAN'S NAME (Type) Reubin Guerrero M.D. | | | | | | 23D. ADDRESS Montebello State Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY CARVER Memorial PARK | | 24D. LOCATION (City, town, or county) (State) LAUREL, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. | | | | ADDRESS 1735 Harford Ave. | | | |



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F. 326

65 1076

BALTIMORE CITY HEALTH DEPARTMENT

65 1076

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PEARL FITZGERALD

2. DATE AND HOUR PRONOUNCED DEAD

1/28/65 3:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1101 Orleans St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

widow

8. DATE OF BIRTH

4-2-1908

9. AGE (In years last birthday)

56

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Columbia, S. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK ANDERSON

14. MOTHER'S MAIDEN NAME

EFFIE ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

219-22-4528

17. INFORMANT

MRS. SARAH E. SYE

ADDRESS

764 LINCOLN ST. #29

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Werner N. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/29/65

EXAMINER'S NAME (Type)

W.U. Spitz, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

2-1-65

23C. NAME OF CEMETERY or CREMATORY

Mt. CALVARY

23D. LOCATION

(City, town, or county) (State)

Ann Arundel Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

1735 Hanford Ave.

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

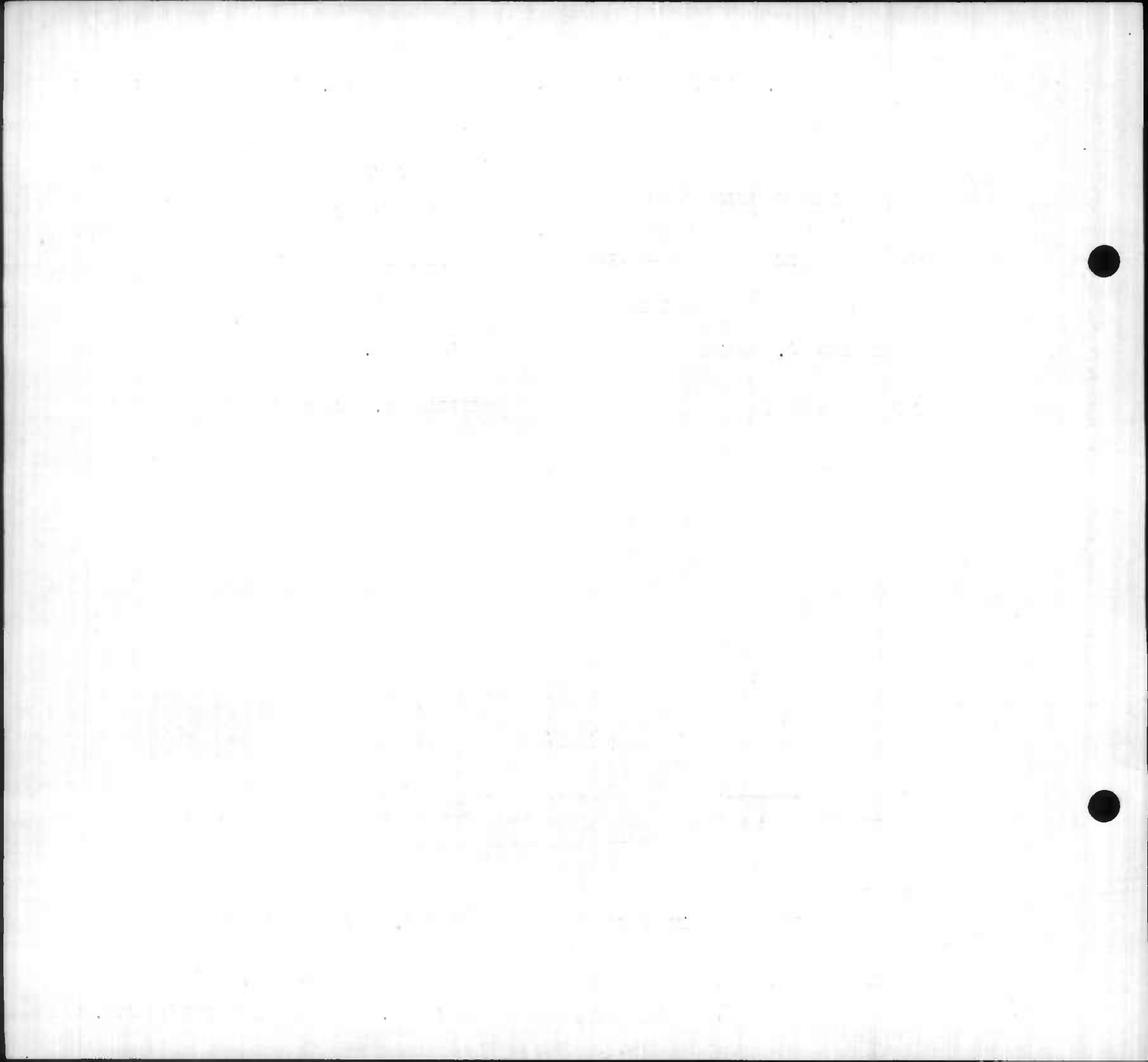
VALLEY FORD

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1077 | |
|---|------------------|--|------------------------------|--|--|--|--|
| BIRTH NO. 65 1077 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | DR. WILLIAM ARTHUR DARBY | | JAN. 27, 1965 5:30 am M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY | |
| 211 GOODALE ROAD | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 27-12 | |
| | | | | D. STREET ADDRESS (If rural, give location) 211 GOODALE ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/19/91 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SURGEON | | 10B. KIND OF BUSINESS OR INDUSTRY MEDICINE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME RICHARD J. DARBY | | | | 14. MOTHER'S MAIDEN NAME LAURA G. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT LILLIAN B. DARBY 211 GOODALE ROAD | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <i>Arrhythmia / fibrillation with failure</i> DUE TO | | 4 weeks. | |
| | | | | (B) <i>Arterio-sclerotic heart disease</i> DUE TO | | 12 years. | |
| | | | | (C) <i>coronary occlusion Dec 1953</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1953</i> to <i>Jan 25 1965</i> , that (I) (we) last saw the deceased alive on <i>Jan 25 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Samuel Whitehouse</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL WHITEHOUSE | | | | 23D. ADDRESS M.D. 3900 N. CHARLES STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/30/65 | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229 | | | |

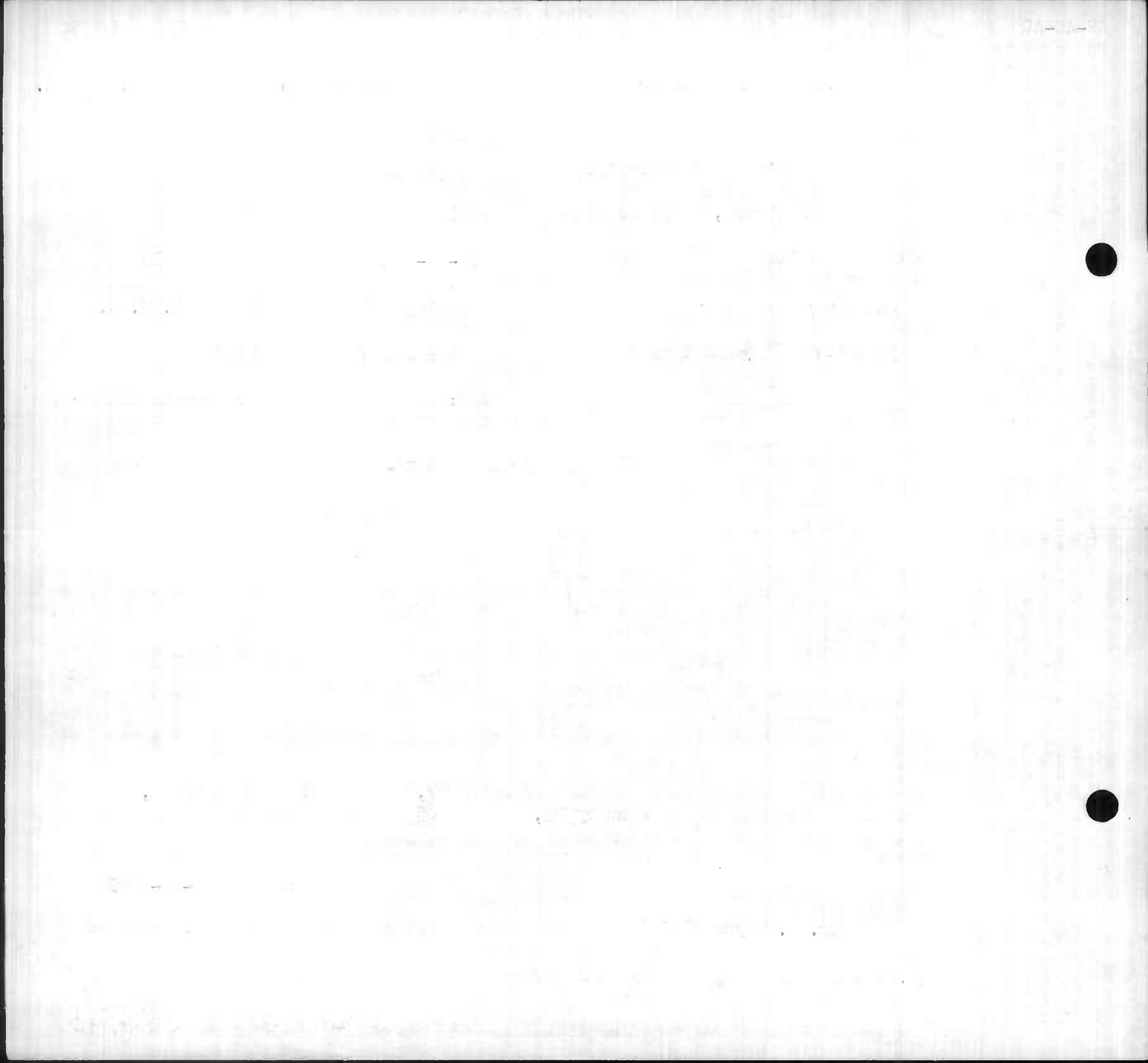


42-40-40
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1078 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1078 | |
|--|--|------------------------|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Joseph Wayne Buecker | | January 29, 1965 | | 10:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE | | B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | Maryland | | | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Male | | | | White | | Single | | 10-16-1964 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| INFANT | | | | | | Maryland, BALTIMORE | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| DONALD F. BUECKER | | | | HELEN M. KECK | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | | | BCH: RECORDS | | 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | Viral Pneumonia | | | | 2 Weeks | |
| ANTECEDENT CAUSES | | | | DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Alveolar Capillary Block | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | | | Yes | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 27, 1965 to January 29, 1965, that (I) (we) last saw the deceased alive on January 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | | |
| S. Wayne Klein | | | | | | 1-29-1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Dr. S. Wayne Klein | | | | M.D. 4940 Eastern Avenue Baltimore, Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| BURIAL | | 2-1-65 | | SACRED HEART CEM. | | 7401 GERMAN HILL RD. BALTO., CO., MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| FEB 1 1965 | | Robert E. Fisher, M.D. | | Charles J. Fisher | | 6224 EASTERN AVE. BALTO., 21224, MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1079 | |
|--|-----------------------------|---|--|--|--|
| BIRTH NO. 65 1079 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Henritta E. RIPNICK | | | 2. DATE AND HOUR OF DEATH 1 - 25 - 65 3:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines Bel-Air Rd. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 25-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 520 Patapsco Ave. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 4-14-1889 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Charles Ripnick | | | 14. MOTHER'S MAIDEN NAME Emma Brandt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Family Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 430.1 I Acute Pulmonary Edema | | | CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarction (B) DUE TO Arteriosclerotic Heart Disease (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 hours n n |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Old Cerebral Thrombosis | | | 19. DATE OF OPERATION 0 | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mosses Pericardial Abscess | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (the hospital) attended the deceased from Apr. 16 19 64 to Jan 25 19 65 . that (I) (last) last saw the deceased alive on Jan 25 19 65 and that in (my) (own) opinion death occurred on the date and hour end from the causes stated above. (I) (the hospital) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/27/65 |
| 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley | | | 23D. ADDRESS 4900 Belair Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1 29 65 | 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS McCully 237 Patapsco Ave. City 25, | |

Best of luck
Best of health
Best of everything

With love & affection

From your mother

For the 1st of May

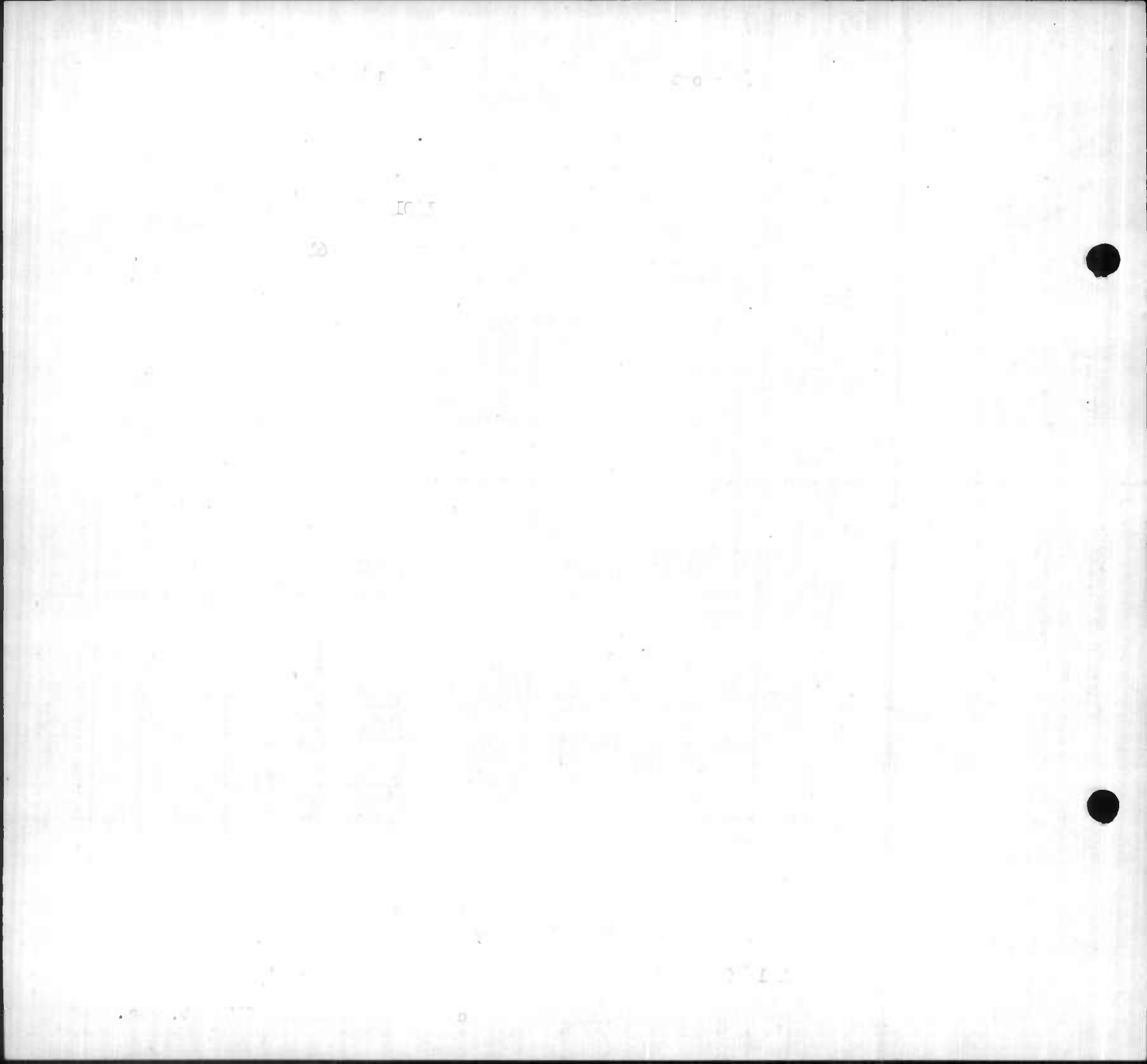
✓

With a copy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1080 | |
|---|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1080 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANNA H. DeLost | | | 2. DATE AND HOUR OF DEATH 1/28/65 12-30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SBGH | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 25-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 1601 CEDDOX ST. | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/20/03 | 9. AGE (In years last birthday) 61 | 10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. |
| 13. FATHER'S NAME FRANK ZUELKE | | | 14. MOTHER'S MAIDEN NAME MARTHA SCHMIDT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT FAMILY ADDRESS SAME |
| 18. CAUSE OF DEATH | | | | | |
| 18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 231X I Compression of the trachea | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 years |
| 18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO Large upper mediastinal mass | | |
| | | | (C) | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Acute respiratory disease | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 1962 to Jan 25 1965 , that (I) (we) lost saw the deceased alive on Jan 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE JIMRE NEUBAUER M.D. | | | | 23B. DATE SIGNED Jan. 29, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) JIMRE NEUBAUER M.D. | | | | 23D. ADDRESS 936 PATAPSCO AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY CEDAR HILL | |
| 24D. LOCATION BALTO, MD. | | (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR MCCULLY FUNERAL HOME ADDRESS 237 Pat. Ave. | |



cdg: 42-52-17

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1081

BIRTH NO. 65 1081

M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)

Frank Holm

2. DATE AND HOUR OF DEATH

January 26, 1965

4:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6911 Norman Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-21-77

9. AGE (In years
last birthday)

87

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired,

Bethlehem Steel Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Finland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frans Holmstrom

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

213-67-3880

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18.

465X + E903.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Yes

WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

6911 Norman Ave (Home)

21D. TIME
OF INJURY

(Month) (Day) (Year) (Hour)

(APPROX.)

3 65 2:30 PM

While At

Work

Not While

At Work

21F. HOW DID INJURY OCCUR?

Fell to floor

22. I certify that (I) (this hospital) attended the deceased from January 3, 1965 to January 26, 1965.

that (I) (we) last saw the deceased alive on January 26, 1965 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Dr. Estelle Connolly

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

January 26, 1965

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-30-1965

24C. NAME of CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

(City, town, or county)

(State)

Eastern Ave. Bal. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

1965 FEB 1

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

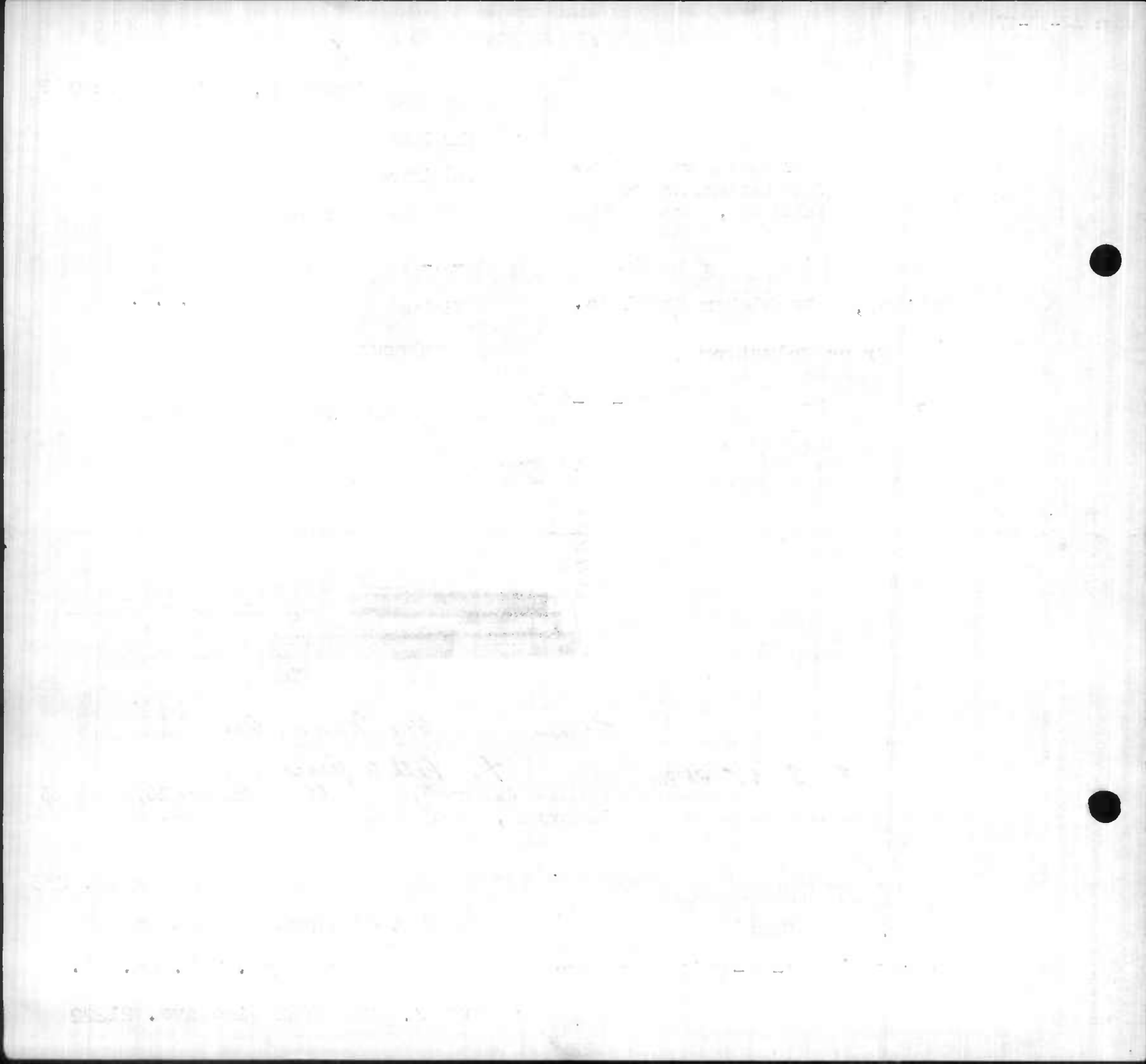
JOHN J. DUDA

ADDRESS

7922 Wise Ave. 21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 1082 | |
|---|---------------------|--|------------------------------------|---|--|
| BIRTH NO. 65 1082 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>5 y/uan Holmes</i> | | 2. DATE AND HOUR OF DEATH <i>January 28, 1965 4:55 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>14-02</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland Gen. Hospital</i> | | D. STREET ADDRESS (If rural, give location) <i>1606 McCulloch St.</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3/30/20</i> | 9. AGE (In years lost birthday) <i>44</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Spurpoint, Md.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Makassar</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Holmes Wm. Swann</i> | | 14. MOTHER'S MAIDEN NAME <i>Alice Holmes</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W.W.II</i> | | 16. SOCIAL SECURITY NO. <i>220-05-7388</i> | | 17. INFORMANT <i>Celia Holmes - wife - same</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH <i>PULMONARY EDEMA + CONGESTION</i> (A) DUE TO <i>ARTEROSCLEROTIC + HYPERTENSIVE CARDIOVASCULAR DISEASE</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>PULMONARY EMBOLI & INFARCTION</i> | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 18, 1965</i> to <i>Jan. 28, 1965</i> , that (I) (we) last saw the deceased alive on <i>Jan. 28, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Holmes Wm. Swann</i> | | | | 23B. DATE SIGNED <i>1-28-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Holmes Wm. Swann</i> | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/1/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Balto. Nat.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | |
| 25C. FUNERAL DIRECTOR <i>William L. Chatman, Jr.</i> | | ADDRESS <i>1701 McCulloch St.</i> | | | |



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Handwritten text, possibly a signature or date, located in the lower left quadrant of the page.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BENJAMIN SAMUEL WOOD

2. DATE AND HOUR PRONOUNCED DEAD

January 26, 1965

4:10 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY
Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cockeysville

D. STREET ADDRESS (If rural, give location)

Gibbon Gibbon Boulevard

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

1-8-1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Road inspector

10B. KIND OF BUSINESS OR INDUSTRY

Balto Co. Roads

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Benjamin S. Wood, Sr.

14. MOTHER'S MAIDEN NAME

Miriam Giles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-03-0925

17. INFORMANT

Mrs. Ethel S. Wood

ADDRESS

ABOVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-29-65

23C. NAME of CEMETERY or CREMATORY

Dulaney Valley Memorial

23D. LOCATION

(City, town, or county)

Cockeysville, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1

1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Brooks Funeral Service, Towson, Md. 21204

2002

20-22-

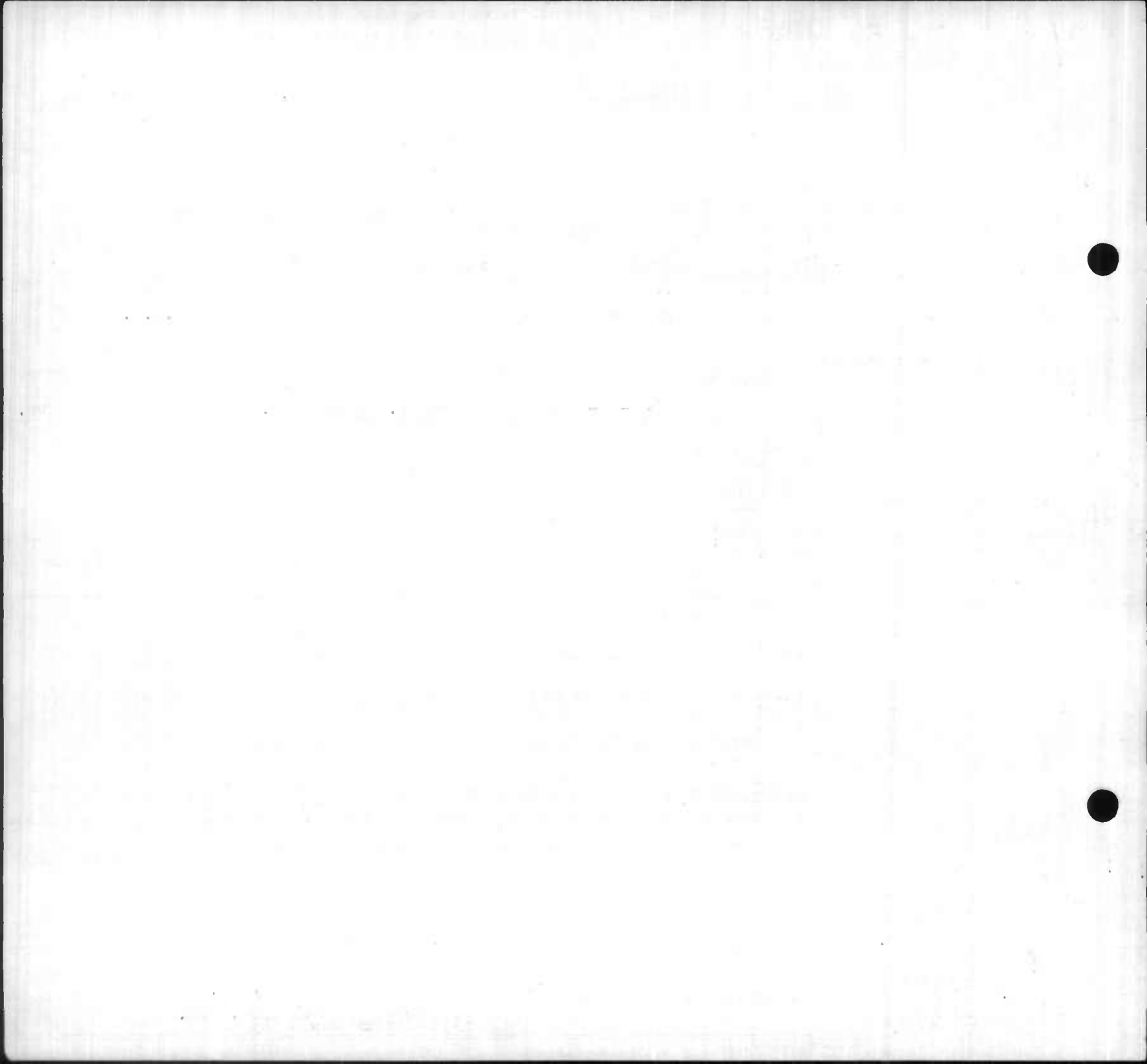
Released by Medical Examiner
252
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1084 | |
|--|--------------|--|-----------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1084 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) William Leo Wisniewski | | 2. DATE AND HOUR OF DEATH Jan 28, 1965 6:15p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION John's Hopkins Hospital BALTO - 5 - Md. | | A. STATE B. COUNTY MARYLAND 26-02 | | | |
| C. CITY OR TOWN BALTIMORE | | D. STREET ADDRESS 4602 Shamrock AVE #13 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 7/14/32 | 9. AGE (In years last birthday) 32 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator | | 10B. KIND OF BUSINESS OR INDUSTRY Beth Steel Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Wisniewski Stanley | | 14. MOTHER'S MAIDEN NAME Wisniewski Jessie | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-28-0703 | | 17. INFORMANT (nee Rebbert) Carolyn Wisniewski (Wife) | |
| 18. 592X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Ventric Epilepsy Chronic glomerulonephritis (B) DUE TO (C) Congestive heart failure | | INTERVAL BETWEEN ONSET AND DEATH 5 mins ? 20 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from Nov 24 1964 to 12-29 1964, that (we) last saw the deceased alive on 12-29 1964 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael J. Dunn | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) Michael J. Dunn | | 23D. ADDRESS John's Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Schlimmer Funeral Home, Inc. | | 25D. ADDRESS 3331 Brehms Lane #12 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1085</u> | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. <u>65 1085</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) CHARLES JOHN STAVROS | | | | January 29, 1965 10:30 am M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL | | | | A. STATE Maryland B. COUNTY 26-03 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 3534 Chesterfield Avenue #13 | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 6/13/90 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | | 10B. KIND OF BUSINESS OR INDUSTRY (Townson) County Coffee Shop | | 11. BIRTHPLACE (State or foreign country) Greece |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME John Stavros | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 220-07-4943 | | |
| 16. SOCIAL SECURITY NO. 220-07-4943 | | | 17. INFORMANT George C. Stavros Sr. son ADDRESS 3534 Chesterfield Ave. | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 10 years Congestive Heart Failure 1 week | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 10 1959</u> to <u>Jan 29 1965</u> , that (I) (we) last saw the deceased alive on <u>Jan 29 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Leonard Wallenstein</i> M.D. | | | | 23B. DATE SIGNED <u>1/29/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Leonard Wallenstein | | | | 23D. ADDRESS 848 W. 36th Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | |
| 24D. LOCATION Baltimore, Md. | | 24E. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | 24F. LOCATION Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR Schimineck Funeral Home, Inc. 3331 Brehms Lane #13 | |



1
J-250

65 1086

BALTIMORE CITY HEALTH DEPARTMENT

65 1086

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES EDWARD JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1965 11:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Bristol

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never married

8. DATE OF BIRTH

6-24-1946

9. AGE (In years last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Edward Jackson

14. MOTHER'S MAIDEN NAME

Bertha Elvora Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Bertha C. Jackson, Bristol MD

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
St. Rt. 408, E. of Sands Rd. Edgewater

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
January 23 '65

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?
Pedestrian struck by motor vehicle.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1/28/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-31-65

23C. NAME of CEMETERY or CREMATORY

Union Chapel McKendrie

23D. LOCATION (City, town, or county)

MD

24A. DATE REC'D BY HEALTH DEPT.

N869-2 FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

William Reese # Anna MC

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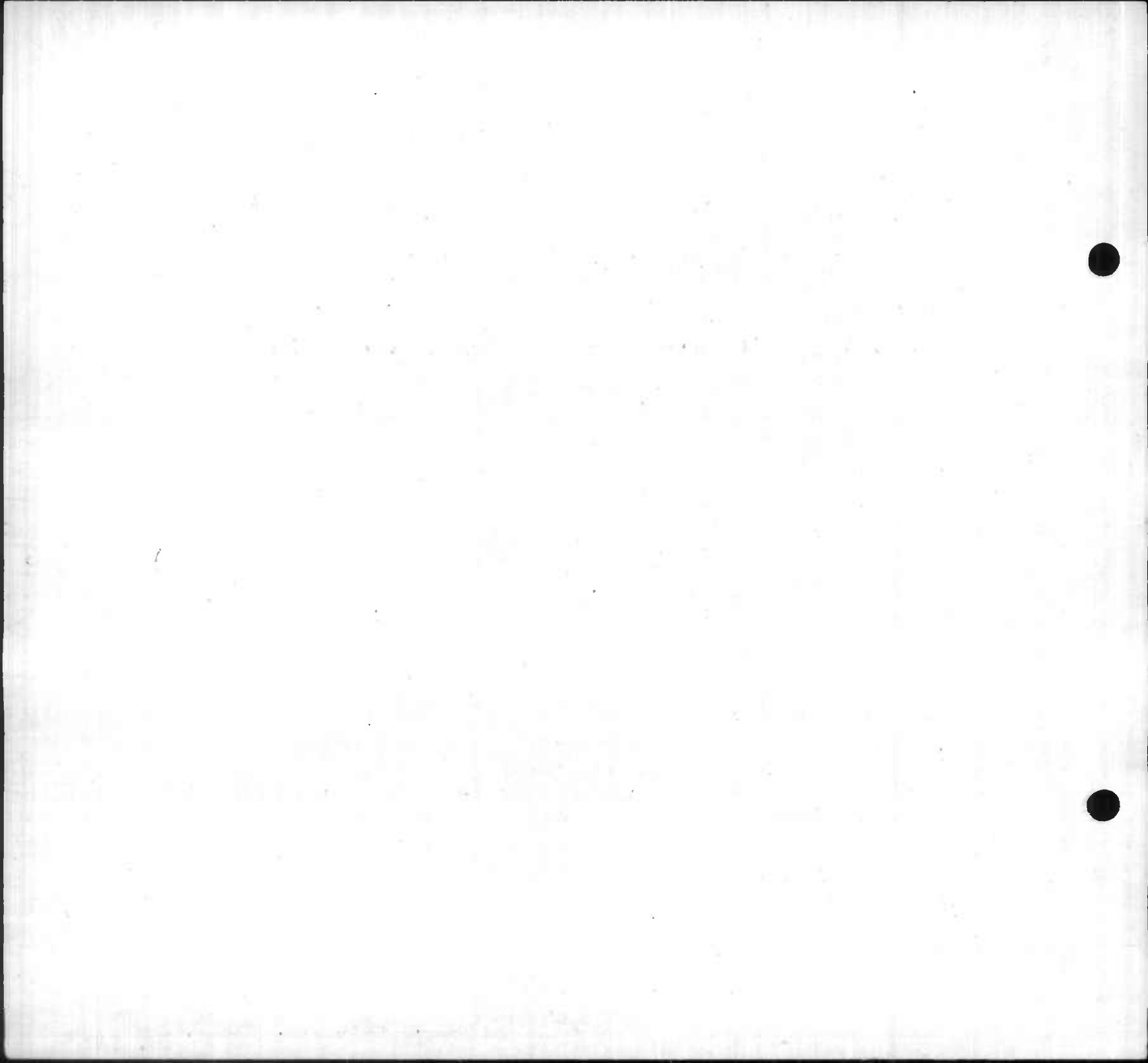
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FUNERAL DIRECTOR: IMPORTANT

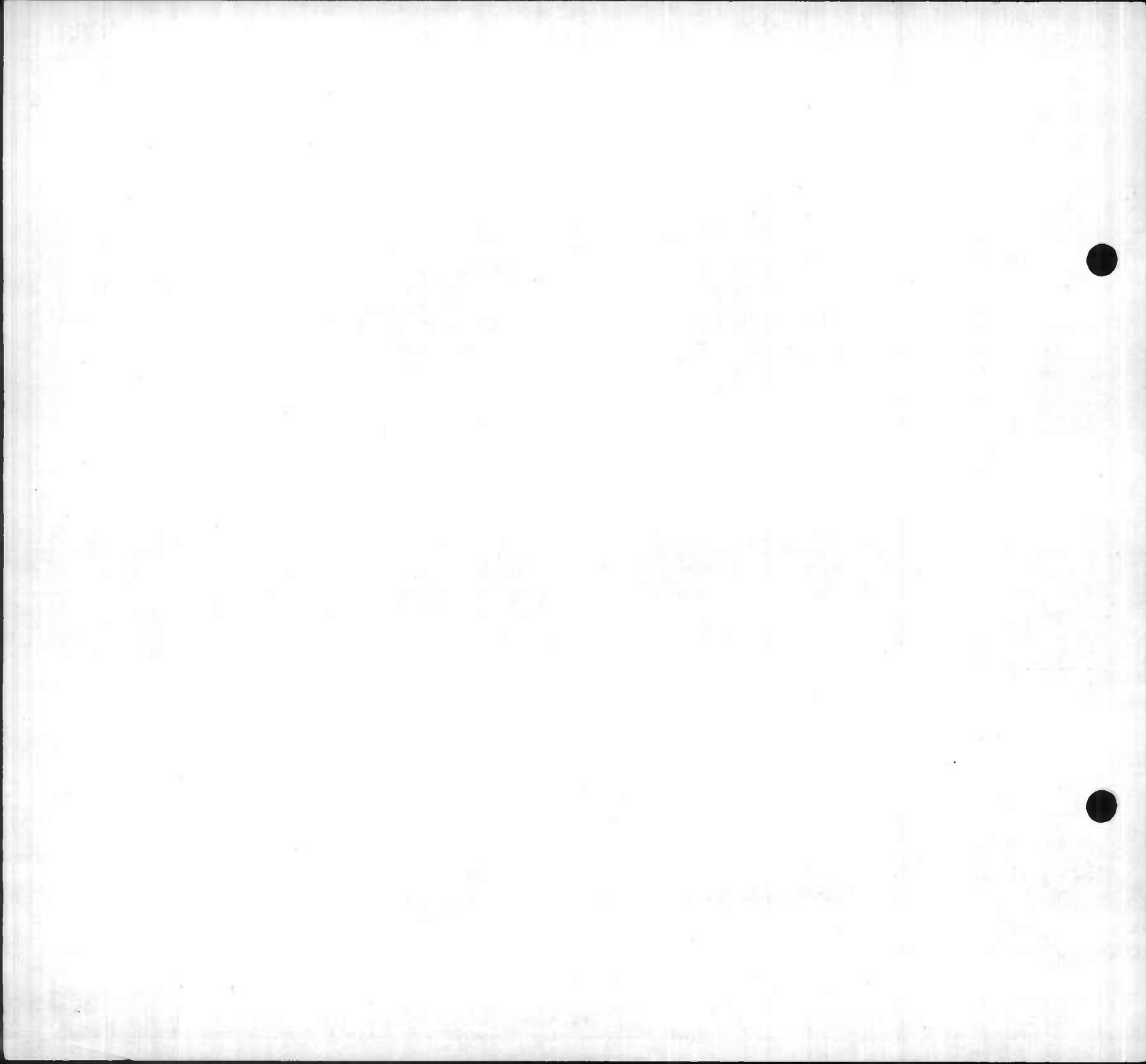
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1087 | |
|---|-------------------------|--|--|---|---|
| BIRTH NO. 65 1087 | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Rev. Francis J. Flanagan</u> | | | 2. DATE AND HOUR OF DEATH <u>1-28-65 - 5 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>11-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 1322 Mt Royal Ave</u> D. STREET ADDRESS (If rural, give location) <u>110 W. 74th St.</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u> | 8. DATE OF BIRTH <u>5/18/10</u> | 9. AGE (In years last birthday) <u>54</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clergy</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>Edward J. Flanagan</u> | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Downey</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of the Colon w/ metastasis to the Liver</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 19. DATE OF OPERATION | | | 20A. AUTOPSY? (Yes or No) | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> 19 <u>65</u> to <u>1-28</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-28</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Vicente R. Carag Jr. M.D.</u> | | | 23B. DATE SIGNED <u>Jan. 28/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>VICENTE R. CARAG JR. M.D.</u> | | | 23D. ADDRESS <u>Bon Secours Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/2/65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>John A. Moran, Inc. 3000 E. Baltimore St. 21224</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Non-med - Dr. Breitkreutz

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1089

BIRTH NO. 65 1089

M.E. CASE NO. 65 1089
1. NAME OF DECEASED
(Type or Print)

Weslie Epps

2. DATE AND HOUR OF DEATH

1/27/65 11:23 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MD Maryland 7-05

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1608 E. Madison St.

5. SEX

M

6. RACE

C

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

N. M.

8. DATE OF BIRTH

6-17-16

9. AGE (In years last birthday)

54

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Marshall Shalpus 942 Chester St.

18. 782.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Cardiac failure

INTERVAL BETWEEN ONSET AND DEATH

year

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐ Not While At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 1 see old chart to 1/20 19 64, that (I) (we) last saw the deceased alive on 1/20 19 64 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J.P. Kokko

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

1/28/65

23C. PHYSICIAN'S NAME (Type)

J.P. Kokko

23D. ADDRESS

M.D. THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/1/65

24C. NAME OF CEMETERY or CREMATORY

McLachlan Cmt

24D. LOCATION (City, town, or county) (State)

Brooklyn

MD

25A. DATE REC'D BY HEALTH DEPT.

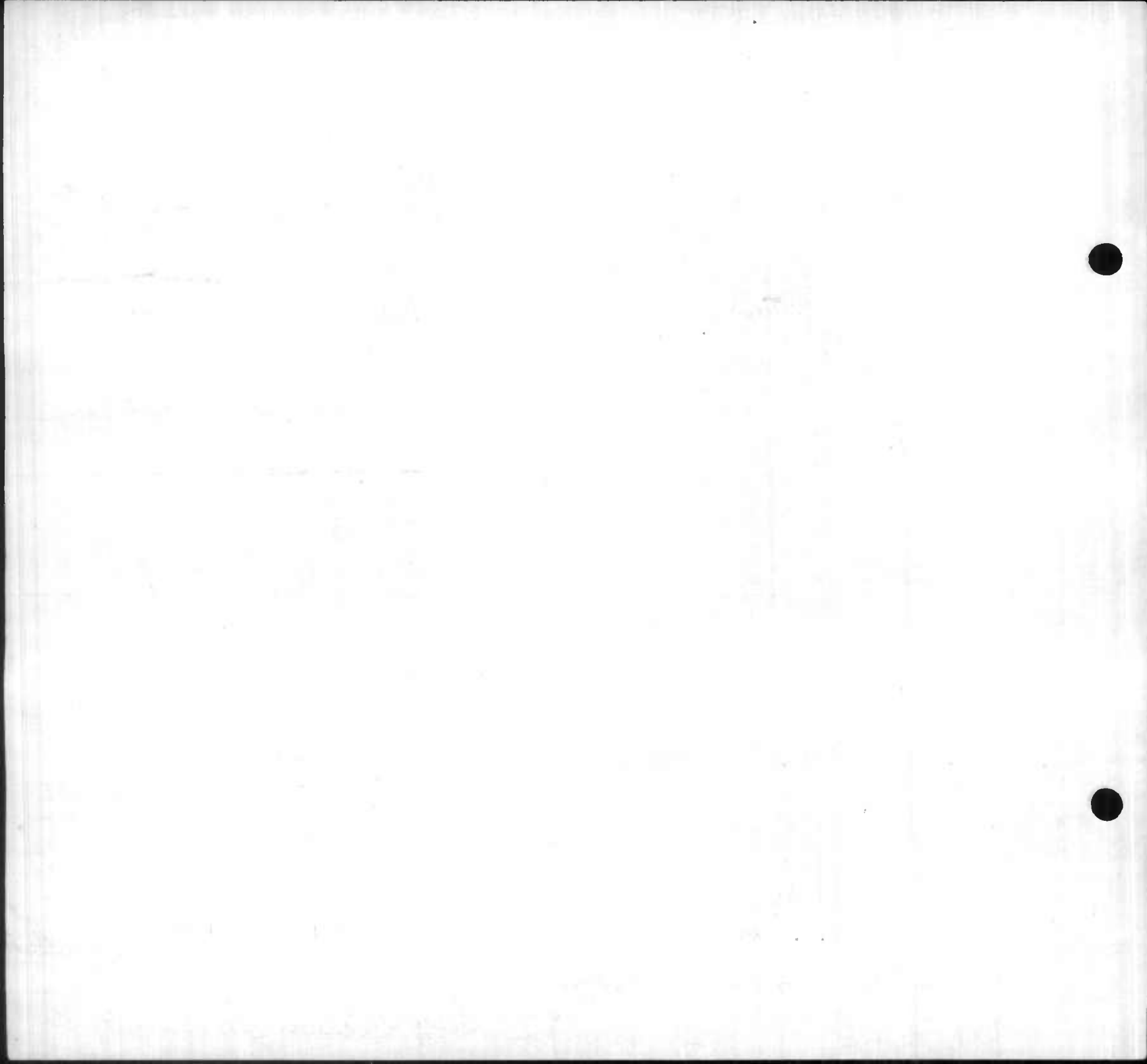
FEB 1 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Choy Chih-ho 1011 Brantley Ave



1

65 1090

BALTIMORE CITY HEALTH DEPARTMENT

65 1090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Michael Clements

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 29, 1965

4:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2806 Carver Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb 25 - 1953

9. AGE (In years
last birthday)

11

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Durham, North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Herman Clements

14. MOTHER'S MAIDEN NAME

Constance Clements

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Cherry Land and Round View Roads

21D. TIME
OF INJURY
(APPROX.)

Jan. 29, 1965 3:20 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

struck by truck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 30, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-3-1965

23C. NAME of CEMETERY or CREMATORY

Cahoon B.Cent

23D. LOCATION

(City, town, or county)

(State)

Durham N.C.

24A. DATE REC'D BY HEALTH DEPT.

N856.2 FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Scarborough & Home not Cawthra

ADDRESS

VALLEY FOLIO

PAID

1901

THE VALLEY FOLIO

1

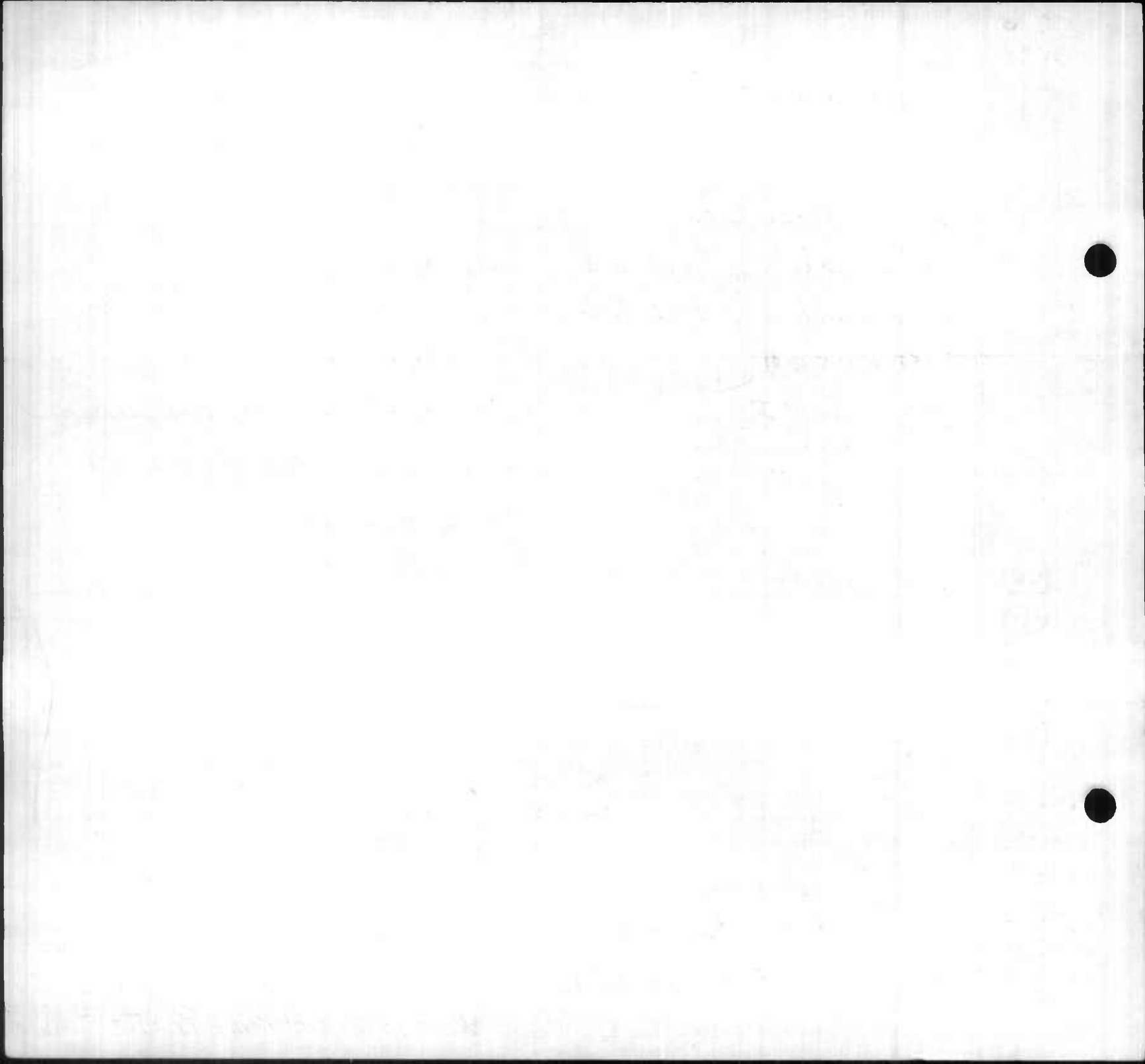
Valley Folio

1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

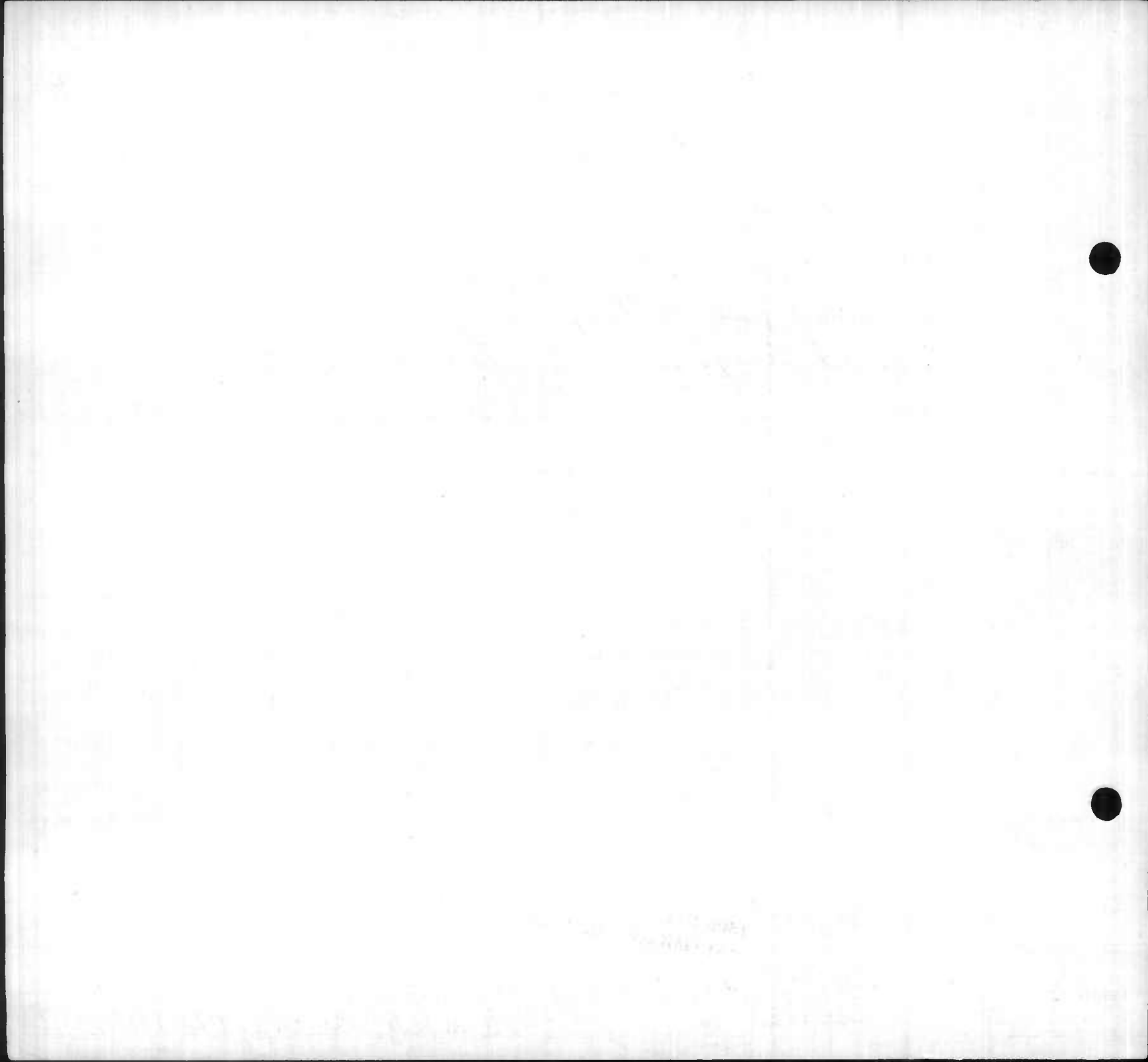
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1091 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 65 1091 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) William A. Shoemaker | | | 2. DATE AND HOUR OF DEATH January 27, 1965 11 am M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 210 S. Calhoun St. | | | A. STATE Maryland B. COUNTY 1903 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 210 S. Calhoun St. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH July 17, 1886 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith | | 10B. KIND OF BUSINESS OR INDUSTRY B.O. RR. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Unknown | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I | | |
| 16. SOCIAL SECURITY NO. 705-03-9414 | | | 17. INFORMANT William L. Shoemaker 1921 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.2 + 322.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute Cardiac Dehydration 16. | | | INTERVAL BETWEEN ONSET AND DEATH 5 yr. | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic myocarditis Renal disease, Hypertension | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Alcoholism | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not-While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 19 to 1-27-65 19, that (I) (we) last saw the deceased alive on 1-25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. E. CAIA | | | | 23B. DATE SIGNED 1/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) A. E. CAIA | | | | 23D. ADDRESS 47 Jullow Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/65 | | 24C. NAME OF CEMETERY or CREMATORY London Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

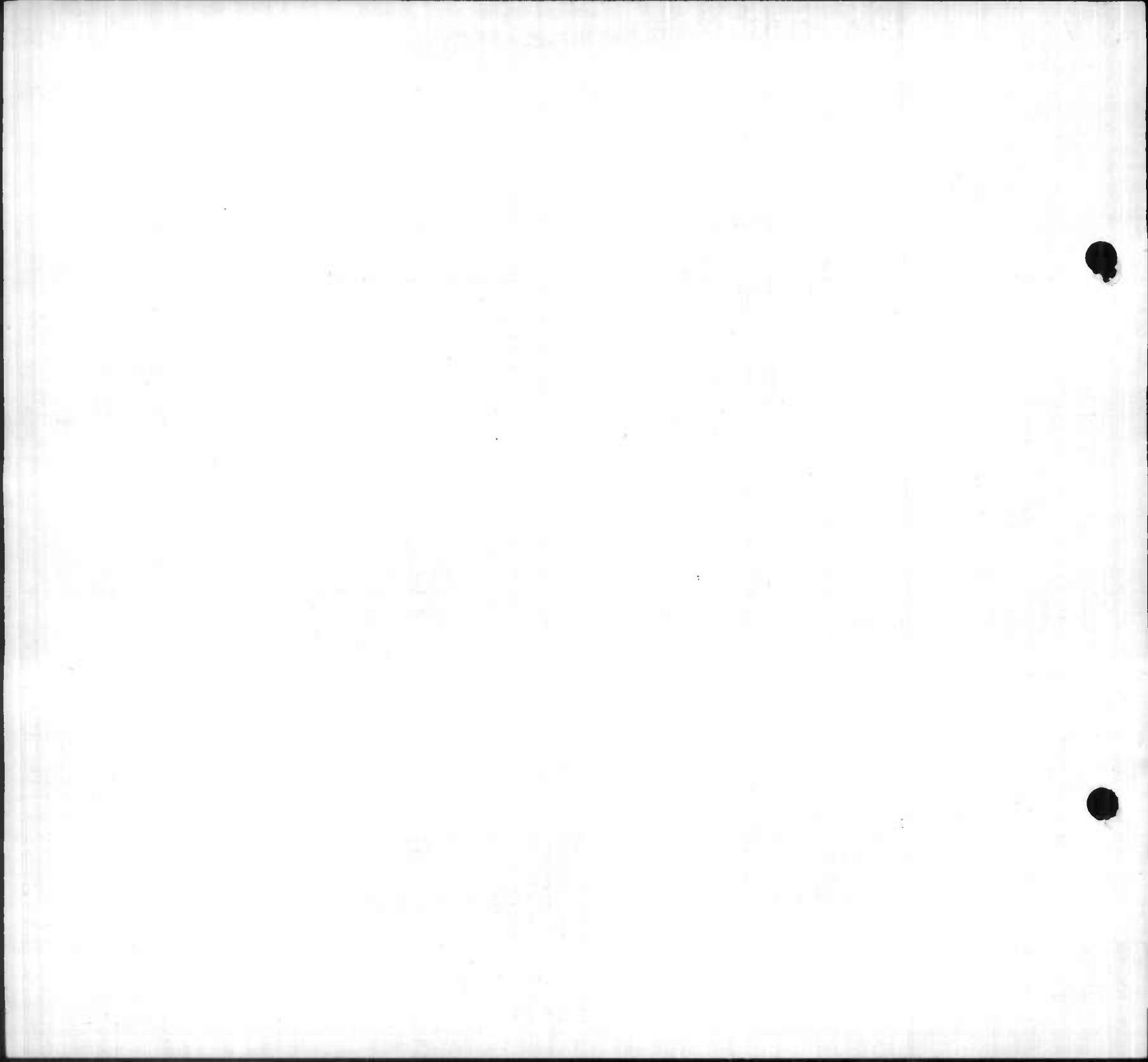
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1092 | |
|---|---|---|---|---|---|
| BIRTH NO. 65 1092 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK K. AUGINS | | | 2. DATE AND HOUR OF DEATH 1/26/65 9 30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY 1703 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 828 Edmondson ave | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | |
| D. STREET ADDRESS (If rural, give location) 828 Edmondson ave | | | | | |
| 5. SEX m | 6. RACE negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH Aug. 14, 1898 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Machine Operator) Factory | | | 11. BIRTHPLACE (State or foreign country) md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Edward Augins | | | 14. MOTHER'S MAIDEN NAME Emma Lucas | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 218-03-6314 | 17. INFORMANT ADDRESS Clarice Brown - 424 E. 26th St. Balto., Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Osteitis deformans (Paget's Disease) of skull | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Duodenal ulcer Hypertensive C.V. Disease | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 17 to Jan 26 19 65 . that (I) (we) last saw the deceased alive on Jan 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE RAYNER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE, MD. 21205 | | | | 23B. DATE SIGNED 1. 27. 65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Carmel mem. P.K. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 24E. FUNERAL DIRECTOR ADDRESS Wm. L. Schatzman Jr. - 1701 M. S. Calhoun St. Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. L. Schatzman Jr. - 1701 M. S. Calhoun St. Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

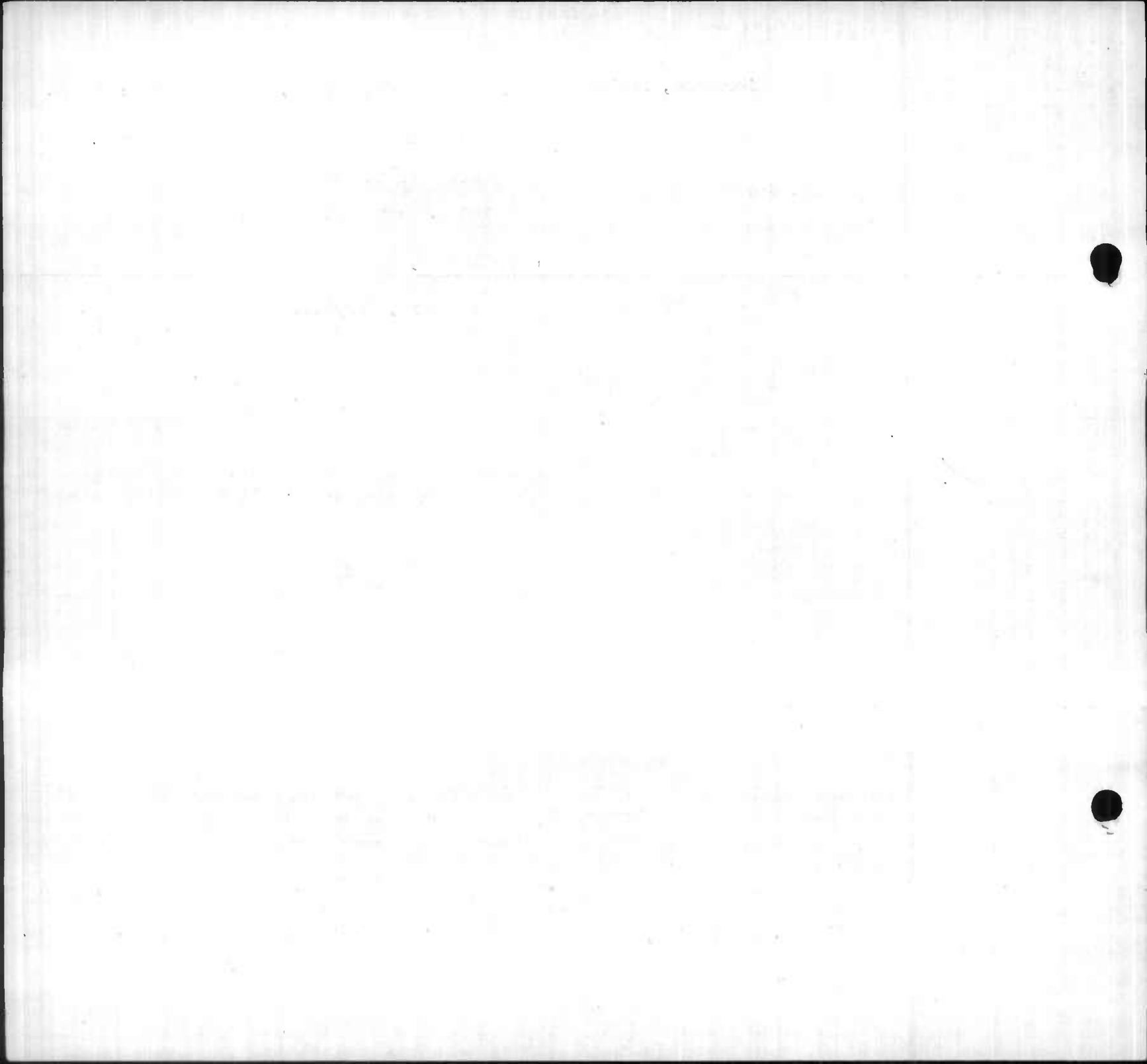
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1093 | |
|--|---------------------|---|---------------------------------|--|---|
| BIRTH NO. 65 1093 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>KYBACKI MRS. FRANCES</i> | | 2. DATE AND HOUR OF DEATH <i>1/27/65</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BON SECOURS HOSPITAL</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTIMORE COUNTY</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>1020 STANFORD RD #29</i> | | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>1897</i> | 9. AGE (in years last birthday) <i>68</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD</i> | |
| 13. FATHER'S NAME <i>PRZYBYLSKI</i> | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>BERNADINE HARTLOVE</i> ADDRESS <i>1020 STANFORD RD.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>Cancer of the Gallbladder</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>1-30-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Vicente R. Carag Jr.</i> M.D. | | | | 23B. DATE SIGNED <i>Jan. 27/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>VICENTE R. CARAG JR.</i> M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1-30-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>HOLY ROSARY CEM</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE CO MD</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i> | | 25C. FUNERAL DIRECTOR <i>JOHN MUEBER JR</i> ADDRESS <i>401 S. CHESTER ST</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

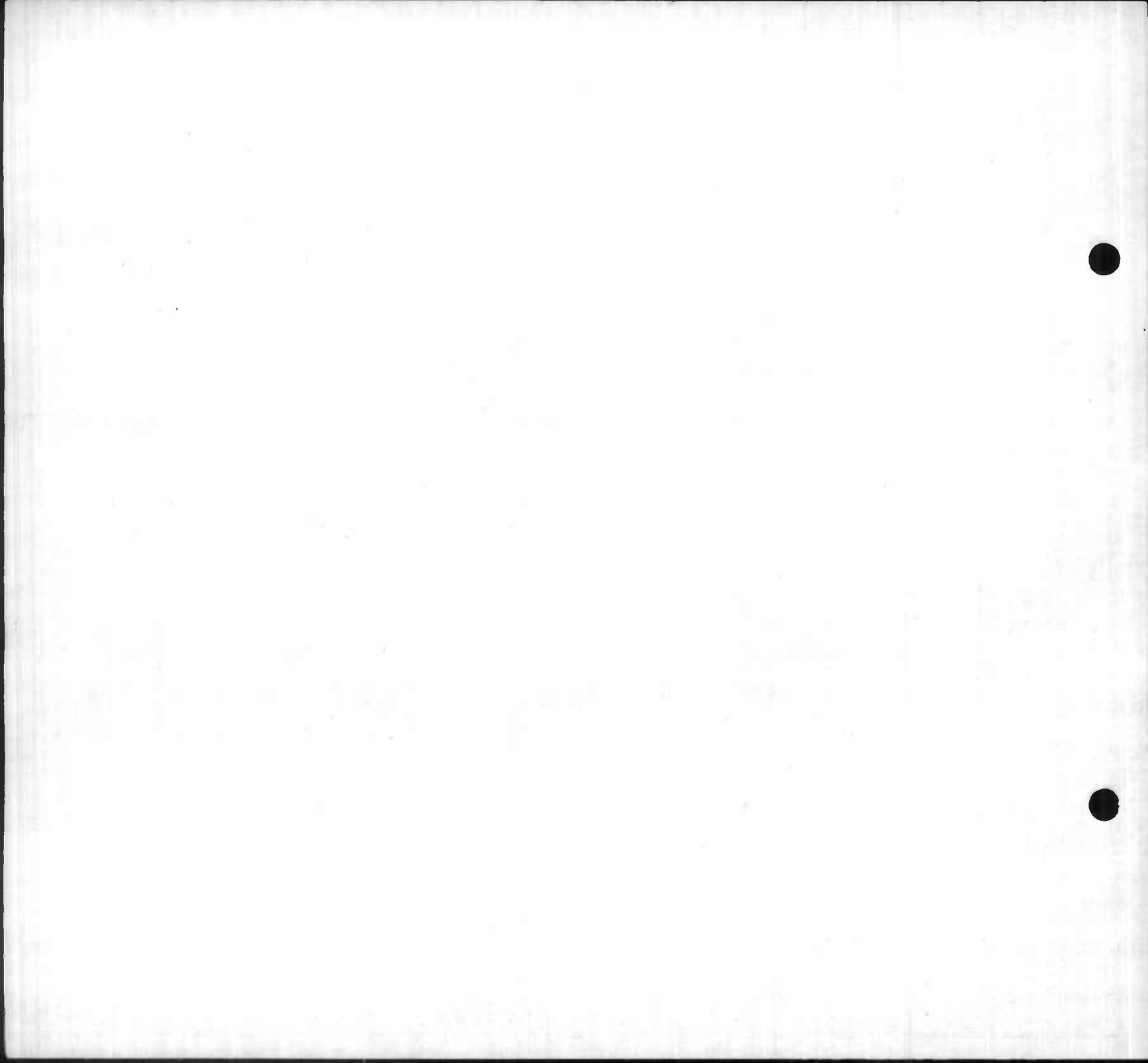
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 1094 | | CERTIFICATE OF DEATH | | Registered No. 65 1094 | |
|---|---------|--|-----------------------------------|---|----------------------------|--|-----------------------------|----------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Lierseman, Louise | | | | January 27, 1965 8:25 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| St. Joseph Hospital | | | | Maryland | | 26-10 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | Baltimore 21224 | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 260 S. East Ave. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| Female | White | Single | March 8, 1895 | 70 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | | |
| | | | Hutzlers | | | Baltimore, Maryland | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Adolph Liersman | | | | Alvina Altenbaugh | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | | | James W. McCann Chesterland, Ohio | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.14-260X | | | | (A) Antero-septal infarct of left ventricle; diabetes mellitus | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (B) DUE TO | | | | | |
| ANTECEDENT CAUSES | | | | (C) | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 9, 1965 to January 27, 1965, that (I) (we) last saw the deceased alive on January 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| William B. VandeGrift, M.D. | | | | January 27, 1965 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| William B. VandeGrift, | | | | 1400 N. Caroline St., Baltimore, Md. 21213 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 1-30-65 | | Moreland Memorial | | Balto. Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | |
| FEB 1 1965 | | Robert E. Farley, M.D. | | Ullrich Funeral Home Baltimore, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

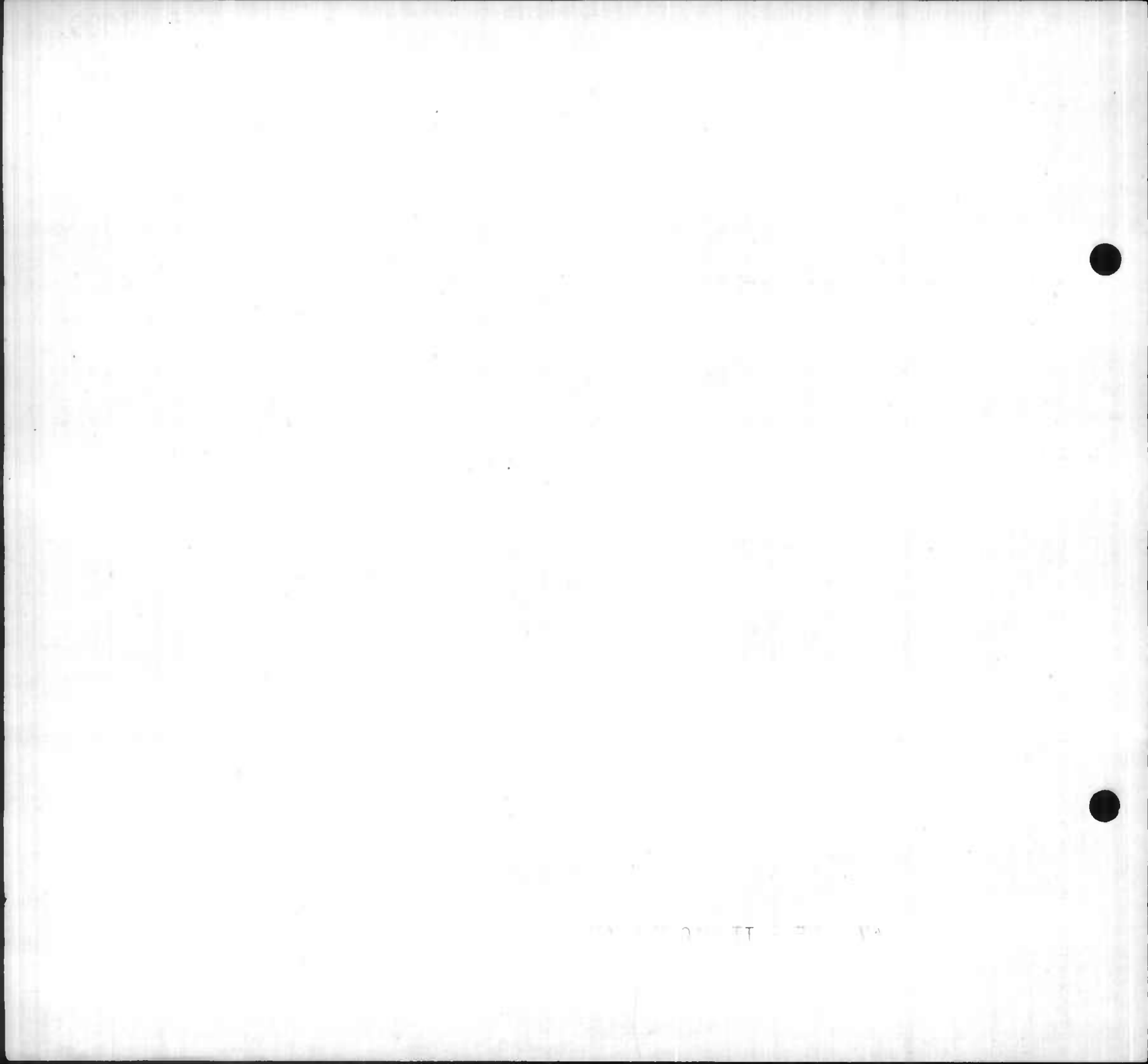
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1095 | |
|---|-----------|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 1095 | | CERTIFICATE OF DEATH | | | | | | X | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Margaret L. Phillips | | | | | | 2. DATE AND HOUR OF DEATH 26 January 1965 7:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital | | | | | | A. STATE Maryland | | B. COUNTY Baltimore | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 600 Martin Blvd. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 19 Feb 1912 | | 9. AGE (In years last birthday) 52 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New Jersey | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Amos | | | | | | 14. MOTHER'S MAIDEN NAME Anna Lund | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS TALLIE PHILLIPS- 600 MARTIN BLVD | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH | | | | | |
| ANTECEDENT CAUSES | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) Myocardial infarction | | | | | |
| | | | | | | (B) Pneumatic heart disease | | | | | |
| | | | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 21 January 1965 to 26 January 1965, that (I) (we) last saw the deceased alive on 26 January 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE L.S. Tilley | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 26 January 1965 | |
| 23C. PHYSICIAN'S NAME (Type) L.G. Tilley | | | | | | 23D. ADDRESS M.D. Maryland General Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 1/27/65 | | 24C. NAME OF CEMETERY or CREMATORY ALPINE CEMETERY | | | | 24D. LOCATION (City, town, or county) (State) PERTH AMBOY N.J. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Talley M.D. | | | | 25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME 4710 BELMONT RD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

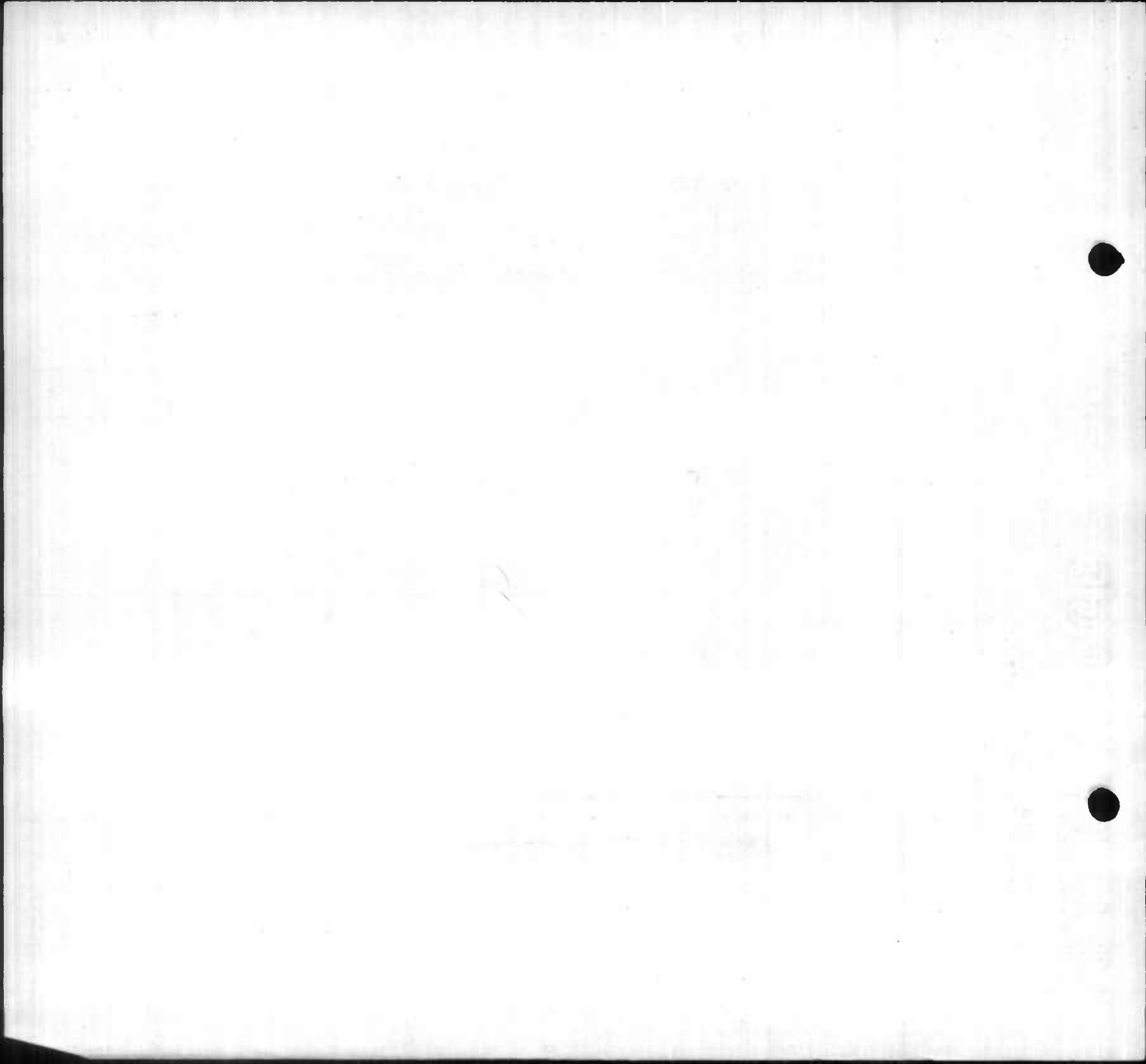
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1096 | |
|---|---|--|--|---|--|--|---------------------------------|
| BIRTH NO. 65 1096 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARGARET CONSTANCE ZANGRILLI | | | | 2. DATE AND HOUR OF DEATH JANUARY 26 1965 5:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 3300 + Calvert BALTIMORE 12, Maryland | | | | A. STATE MARYLAND | | | |
| | | | | B. COUNTY 27-34 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 5505 BELLE VISTA AVE. | | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 8/5/08 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME FRANK BOEHMLEIN | | | |
| 14. MOTHER'S MAIDEN NAME EVA EVANS | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT MRS SHIDLEY ZEBRON | | | |
| 18. 501X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Atelectasis (9 lung), RML DUE TO (B) Asthma bronchitis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 21 1965 to JANUARY 26 1965 , that (I) (we) last saw the deceased alive on JANUARY 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David Merritt Mac Millan | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID MERRITT MAC MILLAN | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/29/65 | | 24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEMETERY | | 24D. LOCATION (City, town, or county) (State) DUNDALK MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME | | ADDRESS 4210 PATTIN RD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

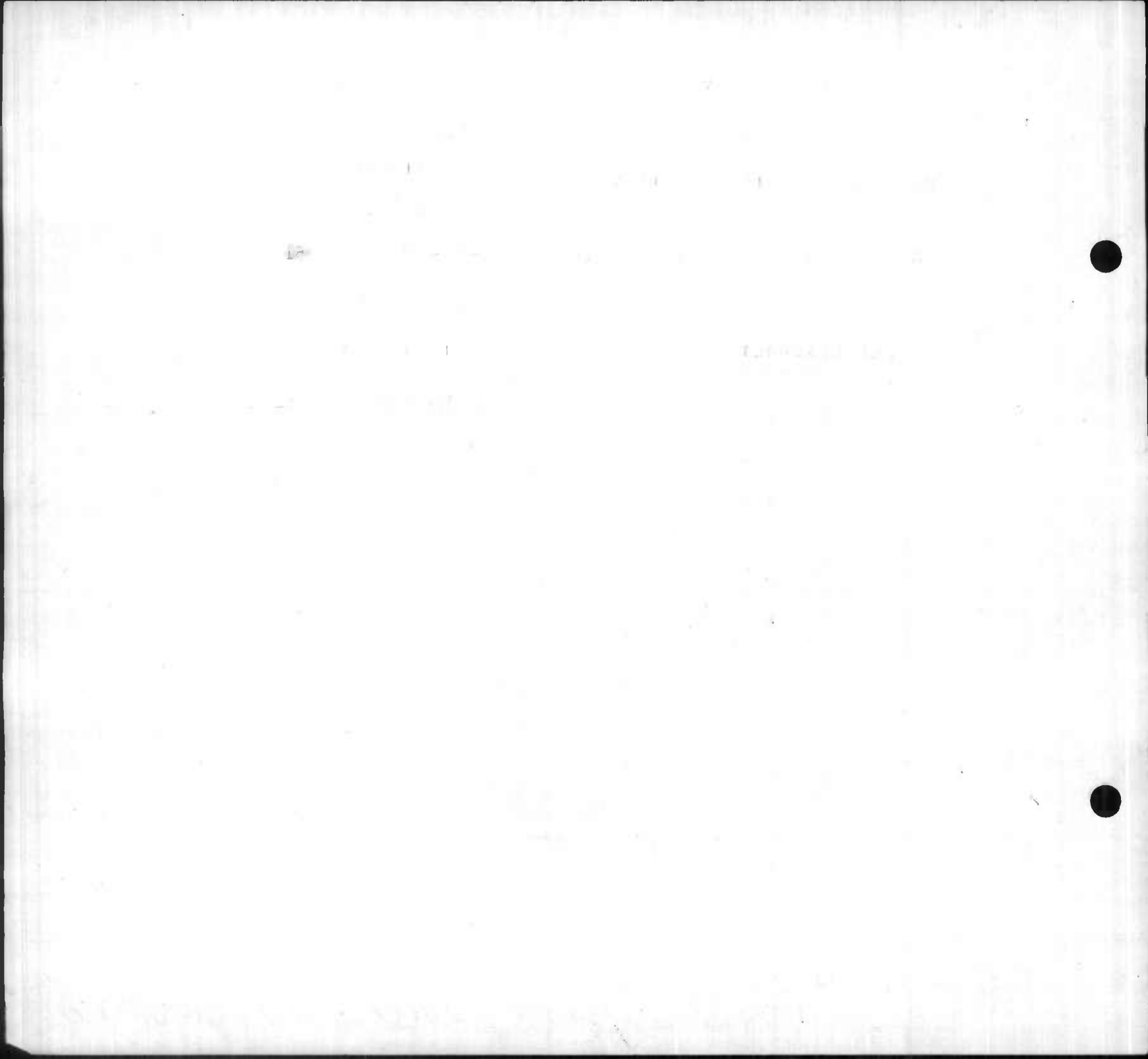
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1097</u> | |
|---|--|---|--|--|--|---|--|
| BIRTH NO. <u>65 1097</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Raymond H. Dempsey</u> | | 2. DATE AND HOUR OF DEATH <u>January 27, 1965</u> <u>7:45 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Ardleigh Nursing Home</u> <u>2095 Rockrose Ave.</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> | | B. COUNTY <u>2602</u> | |
| 5. SEX <u>Male</u> | | | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>Jan. 28, 1877</u> | | 9. AGE (In years last birthday) <u>87</u> | |
| 13. FATHER'S NAME <u>Amos W. Dempsey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza Haines</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-03-6861</u> | | 17. INFORMANT <u>Mrs. Edna Kronmaier 4300 Stanwood Ave.</u> | | | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardio-vascular disease</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 28</u> <u>1964</u> to <u>Jan. 27</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>Jan. 26</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Lloyd E. Saylor</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Jan. 28, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor</u> | | | | 23D. ADDRESS <u>3902 Greenmount Ave.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/30/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Poplar Springs Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Poplar Springs, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Saylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Ullrich Funeral Home 4210 Belair Road.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 1098 | | CERTIFICATE OF DEATH | | Registered No. 65 1098 | |
|--|---------------------|--|--|---|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) BERTHA MALLOW | | 2. DATE AND HOUR OF DEATH 1/28/65 | | 9:30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 1926 EUTAW PLACE | |
| 5. SEX M F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED | | 8. DATE OF BIRTH 2-14-1913 | 9. AGE (In years lost high school) 51 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME LEE LOADHOLT | | | | 14. MOTHER'S MAIDEN NAME DAISEY EARLY | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ivelda Robinson 111-19-131st St. Ozone Pk NYC | | ADDRESS | | | |
| 18. 154X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | (A) DUE TO Cardiac Arrest | | INTERVAL BETWEEN ONSET AND DEATH 1 | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO Carcinomatosis | | unknown | | | |
| | | | | (C) DUE TO Carcinoma of Rectum | | 1 | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from 1/22 19 65 to 1/28 19 65 , that the (we) last saw the deceased alive on 9:30 AM 1/28 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE RD Croon, M.D. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/28/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) RD Croon, M.D. | | | | 23D. ADDRESS Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY My Calvary | | 24D. LOCATION (City, town, or county) (State) a a county md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR A. Holstead 918 Druid Hill | | ADDRESS | | | |



65 1099

BALTIMORE CITY HEALTH DEPARTMENT

65 1099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

January 25, 1965

10:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

504 Gold Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Dec. 22, 1914

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Raleigh N C

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Nelson Baker

14. MOTHER'S MAIDEN NAME

Mary Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Pearl Williams 739 W. North Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/3/65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ann Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

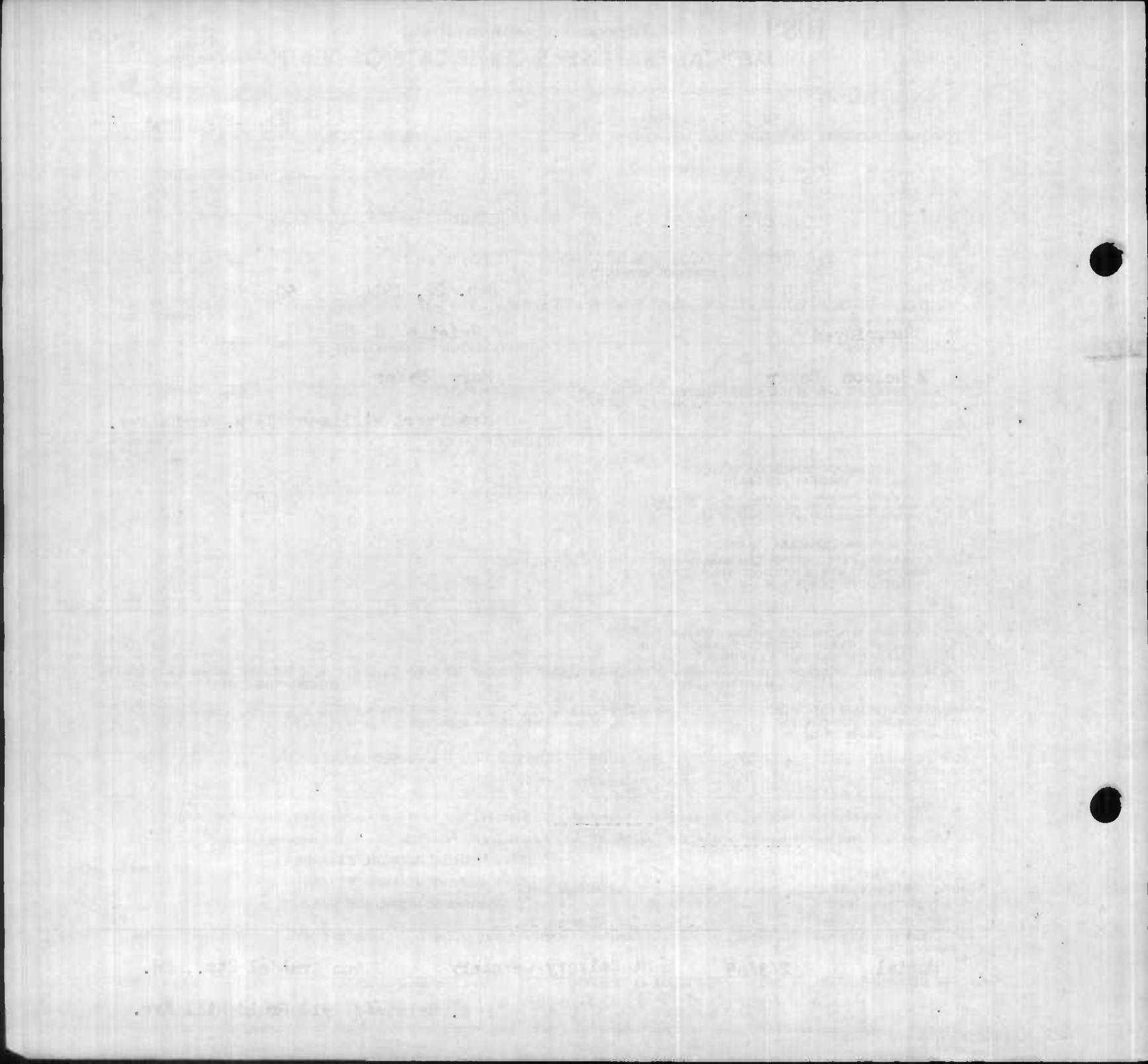
24C. FUNERAL DIRECTOR

ADDRESS

FEB 1 1965

Robert E. Fisher, M.D.

A. Halstead 918 Druid Hill Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 1100

BIRTH NO. 65 1100

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Johnson

2. DATE AND HOUR OF DEATH

January 23, 1965

6:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1800 Warwick Avenue 21216

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2-6-1946

9. AGE (In years
last birthday)

18

10. Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UNEMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James W Johnson, sr

14. MOTHER'S MAIDEN NAME

Sadie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 002.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Pulmonary Insufficiency
DUE TO

2-3 Weeks

(B) Bilateral Pulmonary Tuberculosis
DUE TO

3 Years

(C) Bilateral Pneumothoraces

2-3 Weeks

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Bilateral Thoracotomy Drainage

19A. DATE OF OPERATION

1-14-1965

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Bilateral Pneumothoraces

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 14, 19 65 to January 23, 19 65,
that (I) (we) last saw the deceased alive on January 23, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-23-1965

23C. PHYSICIAN'S
NAME

Dr. Richard Lane M.D.

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/2/65

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetry

24D. LOCATION

(City, town, or county)

A A County Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

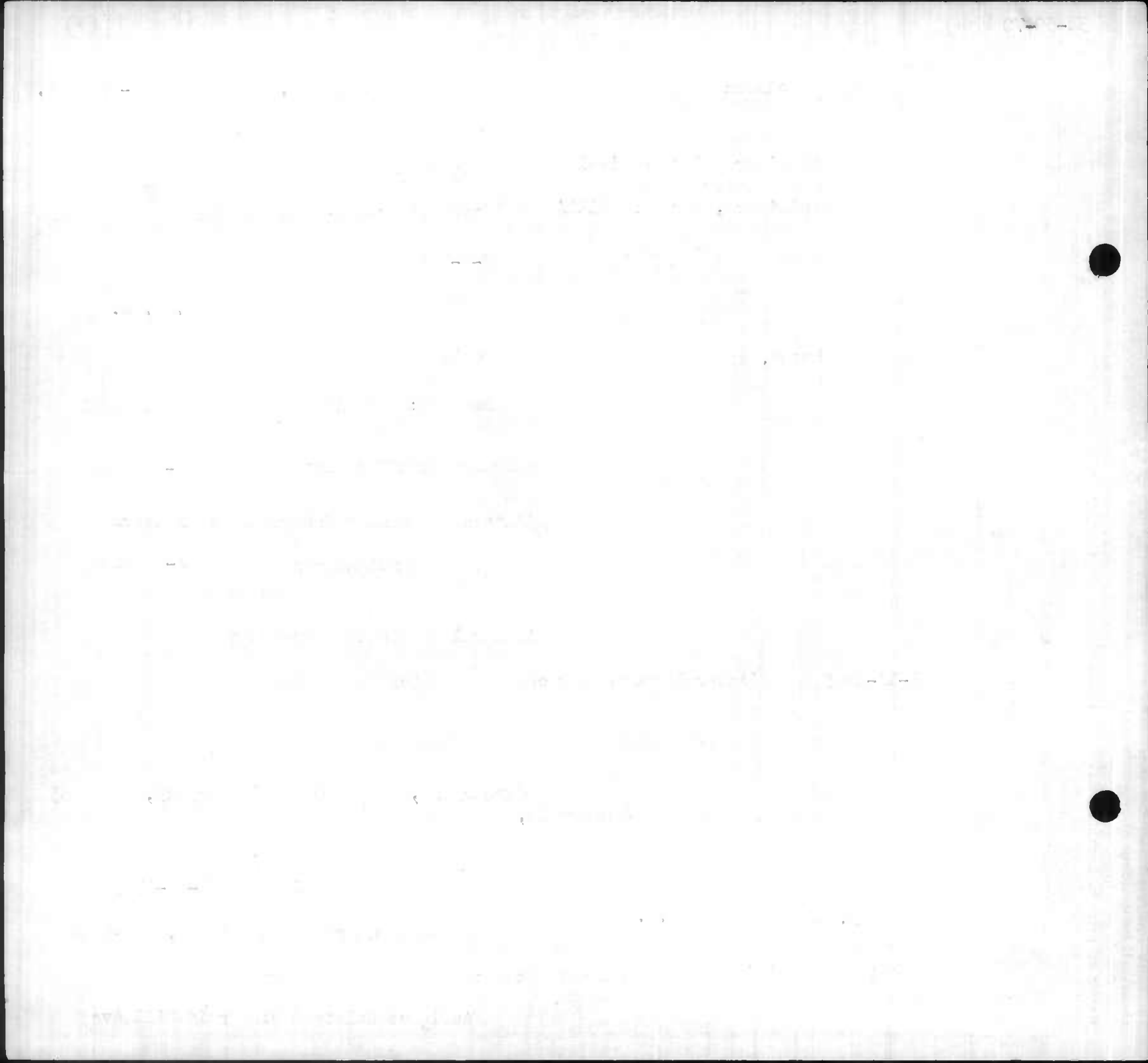
25B. NAME OF REGISTRAR

Robert E. Tasker, M.D.

25C. FUNERAL DIRECTOR

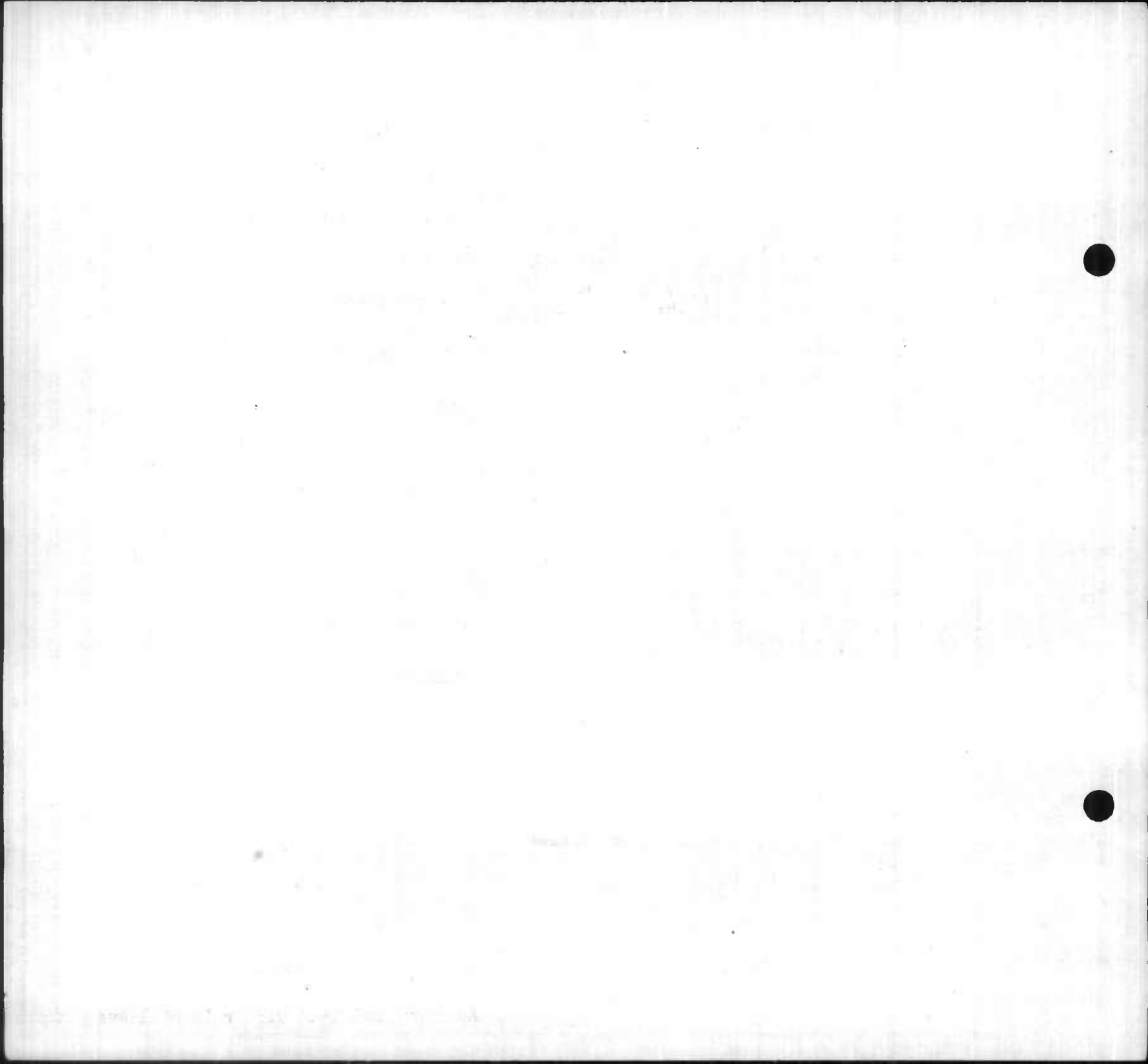
ADDRESS

Adolphus Halstead 918 Druid Hill Ave



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

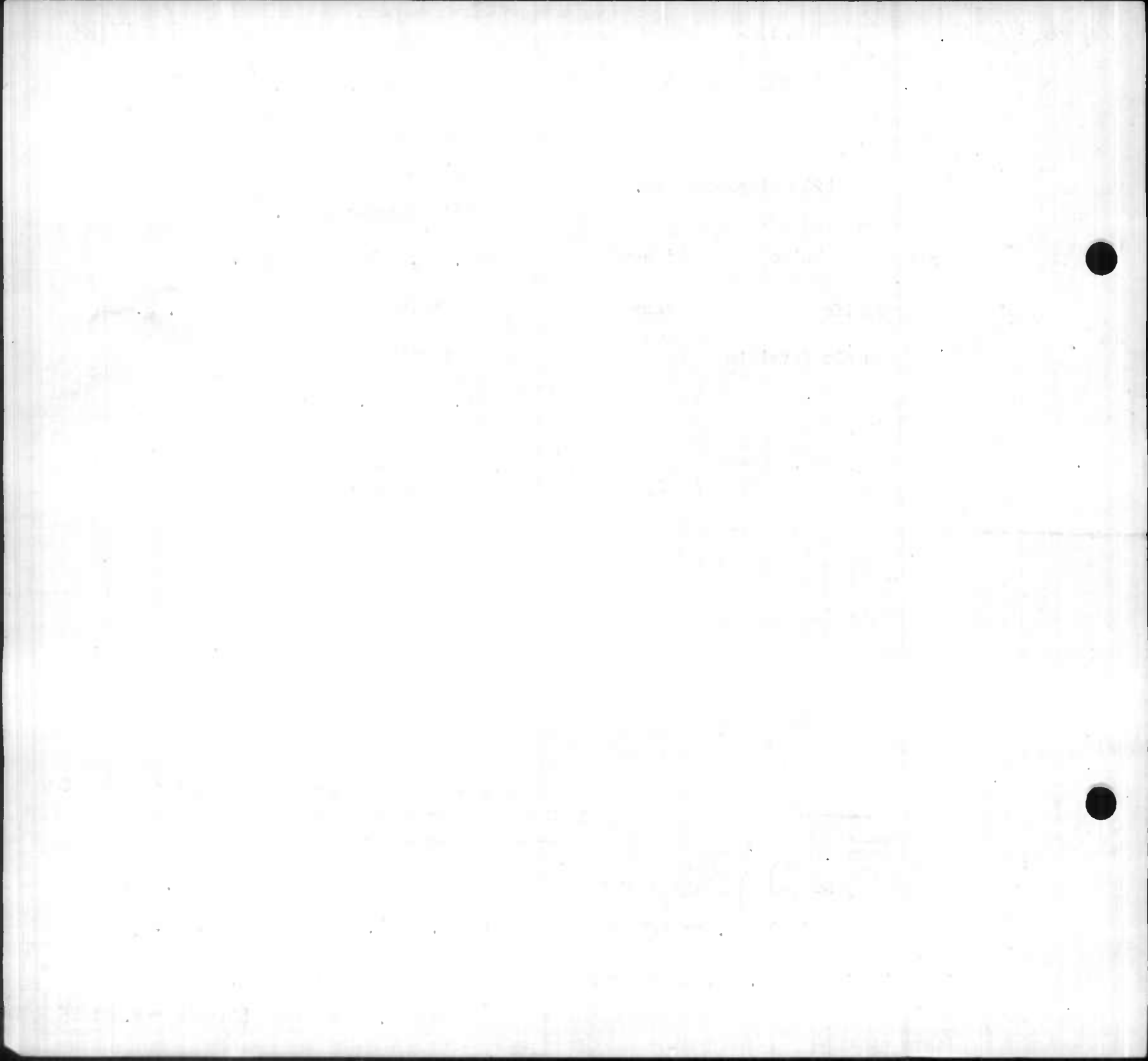
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1101 | |
|--|---------|---|--------------------------|--|--------------------------------|
| BIRTH NO. 65 1101 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | CLIFTON ALEXANDER PAYNE | | JAN. 29, 1965 1 20 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| UNIVERSITY HOSPITAL LOMBARD & GREENE STS. BALTIMORE 1, MD. | | A. STATE MARYLAND B. COUNTY 1702 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 574 OXFORD ST. Ct. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| MALE | NEGRO | NEVER MARRIED | 8/20/14 | 50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| ENTERTAINER | | PROFESSIONAL TAP DANCER | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JOSEPH PAYNE, Sr. | | | CORA GRIFAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | JOSEPH PAYNE, JR. 467 OXFORD CT. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 141.91 | | (A) SQUAMOUS CELL CARCINOMA OF TONGUE, INVASIVE. | | 2 yrs | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| — | | — | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| No | | — | | — | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| — | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | — | |
| 22. I certify that (this hospital) attended the deceased from 1 15 PM Jan 28 19 65 to 1 20 PM Jan 29 19 65, that (we) last saw the deceased alive on Jan 29 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) () (Did) () view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Edward T. Ruley, MD | | | | Jan. 29, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Edward T. Ruley | | University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/3/65 | | MT Calvary Cemetery | |
| | | 24D. LOCATION | | (City, town, or county) (State) | |
| | | A A County Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 1 1965 | | Adolphus Halstead | | 918 Druid Hill Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1102 | |
|--|-------------------------|---|---|---|---|
| BIRTH NO. 65 1102 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) CONCETTA MORTILLARO | | | 2. DATE AND HOUR OF DEATH January 27, 1965 5 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4210 Ridgewood Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-41 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4210 Ridgewood Ave. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH Aug. 29, 1878 | 9. AGE (In years last birthday) 86 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 13. FATHER'S NAME Angelo Fertitta | | | 14. MOTHER'S MAIDEN NAME Salvatora Fava | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Louis D. Mortillaro Same | |
| 18. 296 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) periparturient hemorrhage DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 5 yrs | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/18 19 65 to 1/27 19 65 , that (I) (we) last saw the deceased alive on 1/23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William F. Renner 23C. PHYSICIAN'S NAME (Type) William F. Renner | | | | 23B. DATE SIGNED Jan. 28, 1965 | |
| 23D. ADDRESS 11 W. 29th. St. Baltimore, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment | | 24B. DATE Jan. 30, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Mausoleum | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hwy. 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1103 | |
|---|---------------------|--|--------------------------------------|--|---|
| BIRTH NO. 65 1103 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Bernard Schimmel</i> | | 2. DATE AND HOUR OF DEATH <i>1-28-65</i> <i>9¹⁰ PM</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balt</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Md.</i> | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>28 Greenwood Avenue 6</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | B. DATE OF BIRTH <i>3-28-1886</i> | 9. AGE (In years last birthday) <i>78</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Worker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>National Can Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Co. Maryland</i> | |
| 13. FATHER'S NAME <i>Theodore Schimmel</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>212-03-7163</i> | | 17. INFORMANT ADDRESS <i>Mrs Julia Payne 28 Greenwood Avenue 21206</i> | |
| 18. <i>332 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Thrombosis</i> | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that it (this hospital) attended the deceased from <i>1-7</i> 19 <i>65</i> to <i>1-28</i> 19 <i>65</i> , that it (we) last saw the deceased alive on <i>1-28</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. it (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Dr Douglas Weir</i> | | | | 23B. DATE SIGNED <i>1-28-1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr Douglas Weir</i> | | | | 23D. ADDRESS <i>1213 Light Street</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-1-1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | |
| 24D. LOCATION <i>Baltimore Co.</i> | | 24E. STATE <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Vasey M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Lassahn Funeral Home 7401 Belair Road 36</i> | |

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|-------------------------|--|---|---|-------------------------------------|--|---|--|--|--|-----------------------|--|--|
| BIRTH NO. <i>Virginia</i> 65 1104 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1104 | | | | |
| 1. NAME OF DECEASED (Type or Print) IVEY HORTON | | | | | 2. DATE AND HOUR OF DEATH <i>1-26-65</i> <i>1 9¹⁰</i> M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOKINS HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 7-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1023 N. WASHINGTON ST. | | | | | | | | | |
| 5. SEX MALE | | 6. RACE NEGRO | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 12-18-64 | | 9. AGE (In years last birthday) 1 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) <i>Na.</i> | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | 13. FATHER'S NAME Ivey Horton | | | | | 14. MOTHER'S MAIDEN NAME Lena Williams | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT <i>Ivey Horton Sr. 1023 N. Washington St</i> | | | | |
| 18. 7545 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (A) CAUSE OF DEATH <i>(A) Cardiac Standstill</i> <i>(B) Total Anomalous Venous Return to Heart, Post Operatively.</i> <i>(C) Congenital Heart Disease</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i> | | | | |
| 19A. DATE OF OPERATION <i>3/26/65</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Congenital Heart Disease</i> | | | | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/19</i> 19 <i>65</i> to <i>1/26</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>1/26</i> 19 <i>65</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>R. D. Croom, M.D.</i> | | | | | 23B. DATE SIGNED <i>1/26/65</i> | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>R. D. Croom, M.D.</i> | | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | 24B. DATE <i>1/26/65</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY <i>Bethel Mt Cem</i> | | | | |
| 24D. LOCATION (City, town, or county) (State) <i>3801 Federal Ave Md</i> | | | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | | | |
| 25C. FUNERAL DIRECTOR <i>Zorah T. Elchison</i> | | | | | 25D. ADDRESS <i>1129 N. Carroll St</i> | | | | | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAFAEL RODRIQUEZ

2. DATE AND HOUR PRONOUNCED DEAD

1/28/65 3:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1001 J St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7/22/1912

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Wilder

10B. KIND OF BUSINESS OR INDUSTRY

Ship Yard

11. BIRTHPLACE (State or foreign country)

Humaco Poto Rico

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Pedro Lopez Cedeno

14. MOTHER'S MAIDEN NAME

Encarnacion Rodriquez

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

219-09-3218

17. INFORMANT

Ida Stewart

ADDRESS

1001 J St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Extensive 3rd degree burns

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

ship

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Globe Explorer (ship)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1 28 65 2p.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

clothing caught fire while welding

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/29/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/1/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

A. A. County Md.

24A. DATE REC'D BY HEALTH DEPT.

N 748.2 FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Joseph T. Elickson 1129 N. Camden St.

ADDRESS

WALLLEY FORTNIGHTLY

NO. 100

10

39-11-59 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1106

BIRTH NO. 65 1106

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Bobbie Herbert Chase

2. DATE AND HOUR OF DEATH

1-30-65

12:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

539 Robert Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1-21-48

9. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Herbert Chase

14. MOTHER'S MAIDEN NAME

Evelyn C. Brown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

160.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(A) Naso Epithelioma
DUE TO

November 1963

(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

(B) _____
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-22-1964 to 1-30-1965,
that (I) (we) last saw the deceased alive on 1-30-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-30-65

23C. PHYSICIAN'S
NAME (Type)

Richard Lane

M.D.

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

25B. NAME OF REGISTRAR

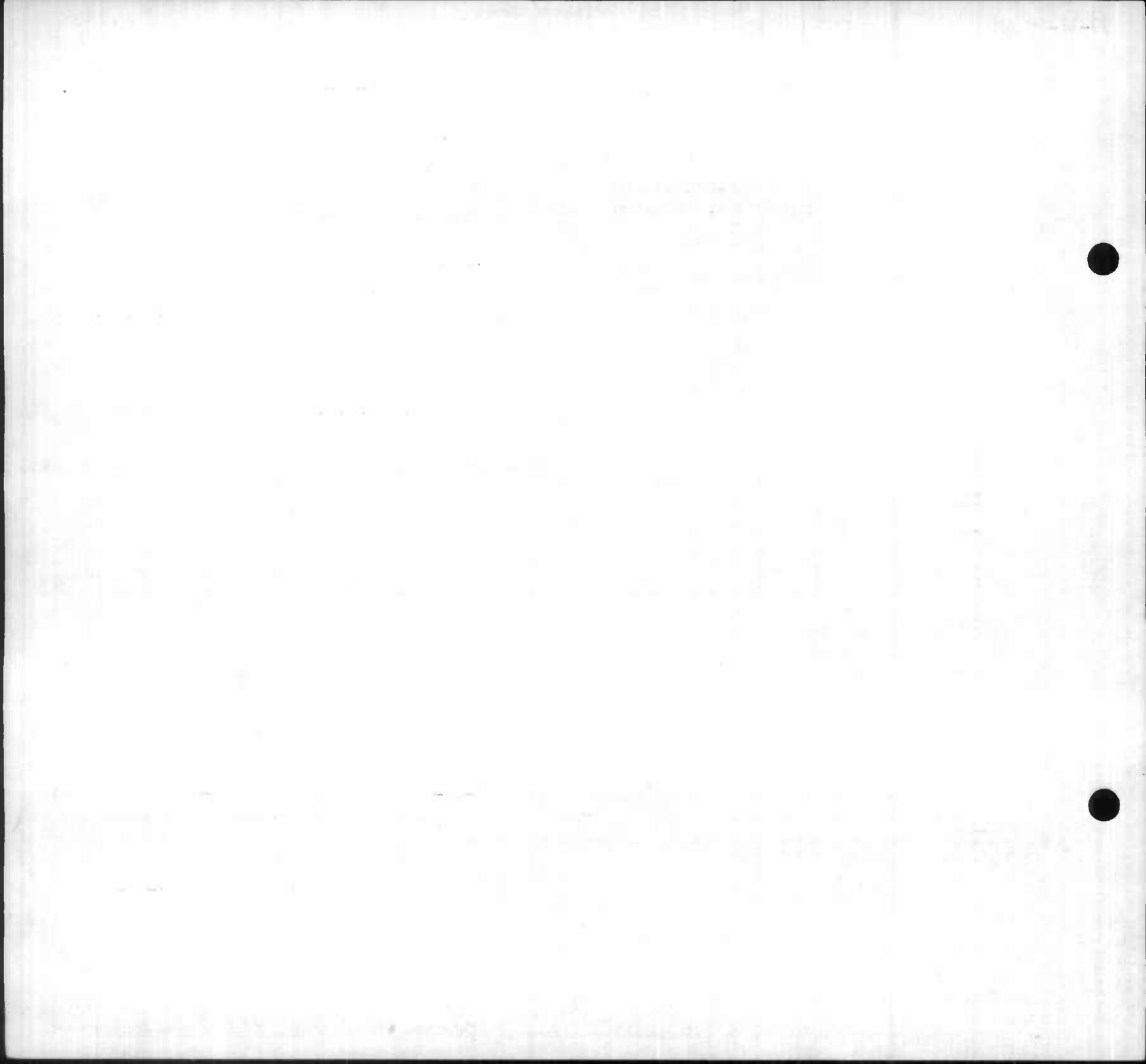
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

George J. Kilom

ADDRESS

1340 N. Calhoun St.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND E. SPRINKLE

2. DATE AND HOUR PRONOUNCED DEAD

1/28/65 7:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3522 Roland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3522 Roland Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

Jan. 4, 1889

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Thomas Sprinkle

14. MOTHER'S MAIDEN NAME

Matilda Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212 10 9928

17. INFORMANT

ADDRESS

Mrs. Irma Shay 3520 Roland Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/29/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Feb. 2, 1965

23C. NAME OF CEMETERY or CREMATORY

St. Mary's (Hampden)

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Road

ADDRESS

Horne F. Burgee

WALLACE POLICE

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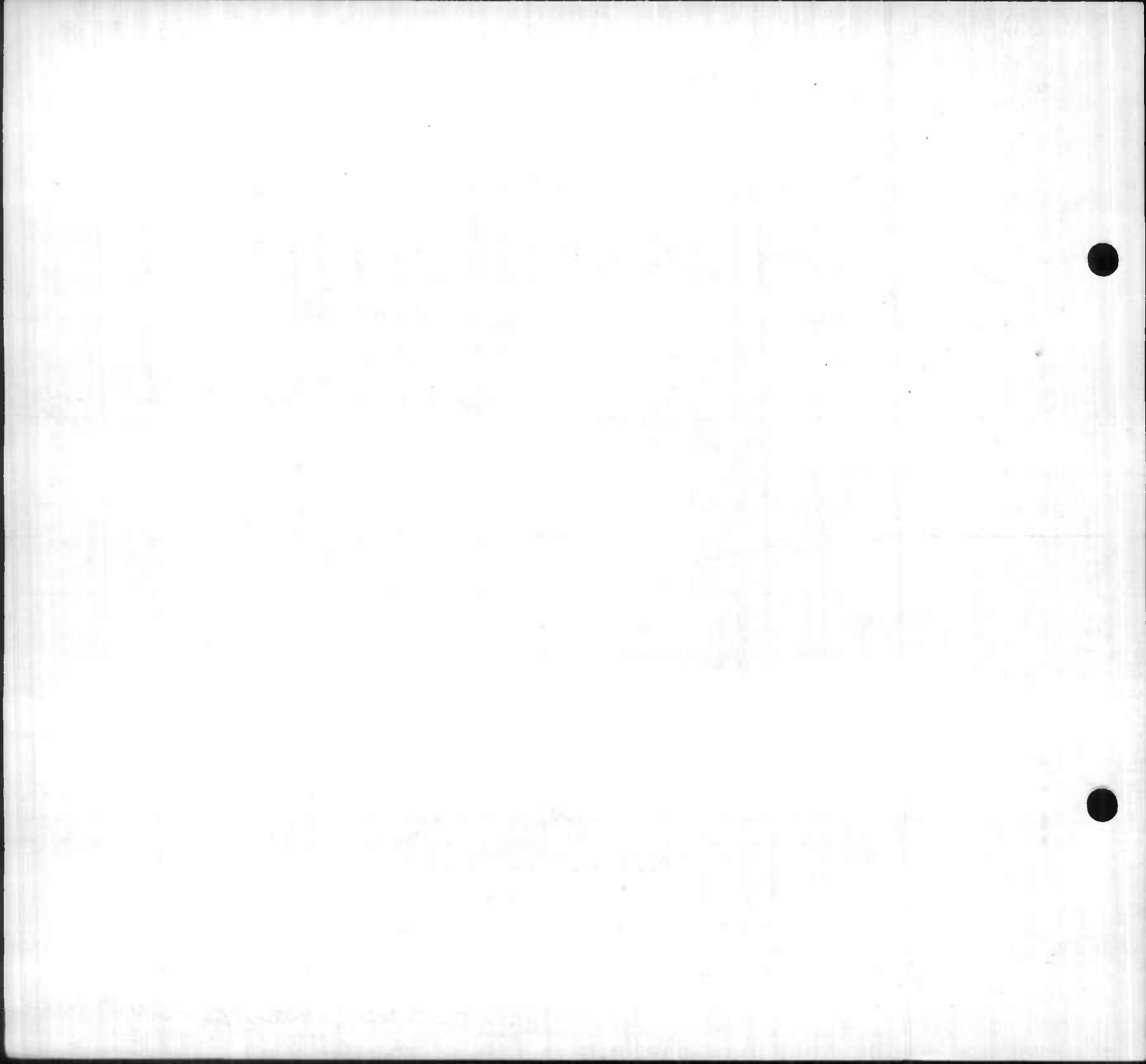
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

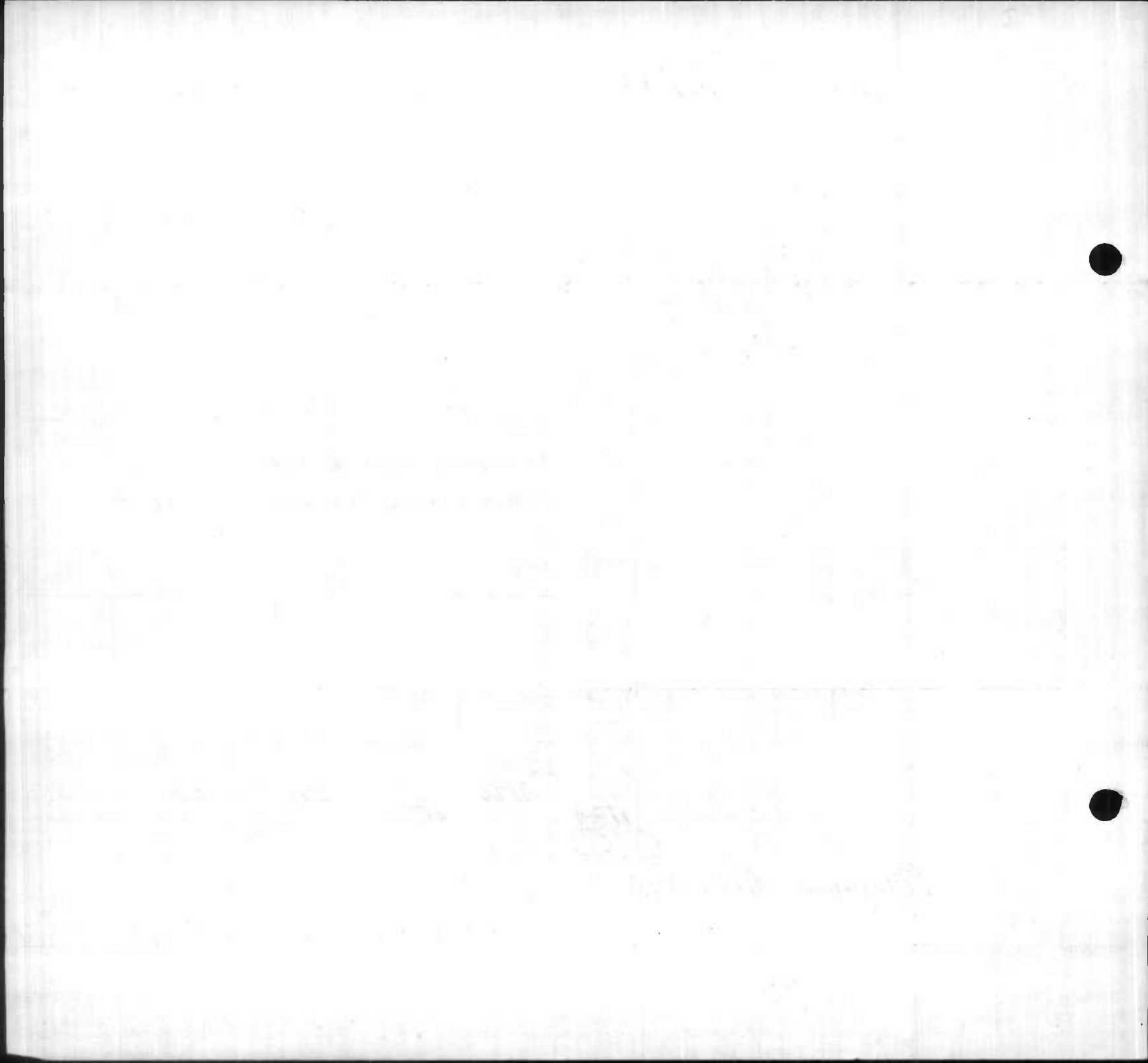
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|--|---|--|--|--|-------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1108 | | | | |
| BIRTH NO. 65 1108 M.E. CASE NO. H. | | | | | 2. DATE AND HOUR OF DEATH 1/28/65 13:30 P.M. | | | | |
| 1. NAME OF DECEASED (Type or Print) GRACE, THAYER | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-15 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| D. STREET ADDRESS (If rural, give location) 1313 W. COLD SPRING LANE | | | | | | | | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Nov 1-1879 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Andrew Haines | | | 14. MOTHER'S MAIDEN NAME Katherine Trummer | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Katherine A. Gross 1310 Cold Spring Lane | | | | |
| 18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) GASTRO INTESTINAL DUE TO HEMORRHAGE (B) LIVER CIRRHOSIS DUE TO (C) | | | | |
| 19. 581.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27 19 65 to 1/28 19 65, that (I) (we) last saw the deceased alive on 1/28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE P. Balogot | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/28/1965 | | |
| 23C. PHYSICIAN'S NAME (Type) R. Leonard Kotz | | | | | 23D. ADDRESS Sinai Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Feb 1-1965 | | 24C. NAME OF CEMETERY or CREMATORY Meadow Branch | | 24D. LOCATION (City, town, or county) (State) Carroll Co., Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Burgee Funeral Home | | ADDRESS 3631 Falls Road Honore F. Burgee | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1109 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 1109 | | CERTIFICATE OF DEATH | | 65 1109 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) NETTIE RALL (NEE SAUTER) | | | |
| 2. DATE AND HOUR OF DEATH | | JAN. 29 th 1965 8 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 1114 S. CONKLING ST. | | MD. 26-09 | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| FEMALE | | WHITE | | WIDOWED | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 3/1/91 | | 73 | | USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| AT HOME | | | | MD. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| HENRY SAUTER | | MARG. REUTER | | NO | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| IV ONE | | RAYMOND REYNOLDS | | 1102 S. CONKLING | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) CEREBRAL HEMORRHAGE | | 3 days | |
| ANTECEDENT CAUSES | | (B) DUE TO | | 10 yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/26 1957 to 1/30 1965, that (I) (we) last saw the deceased alive on 1/29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Benjamin H. Gastein | | | | 1/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| BENJAMIN H. GASTEIN | | 121 S. HANCOCK AVE BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 2/1/65 | | DAK LAWN | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 1 1965 | | Robert E. Taylor, M.D. | | 3218 HUDSON ST. | |

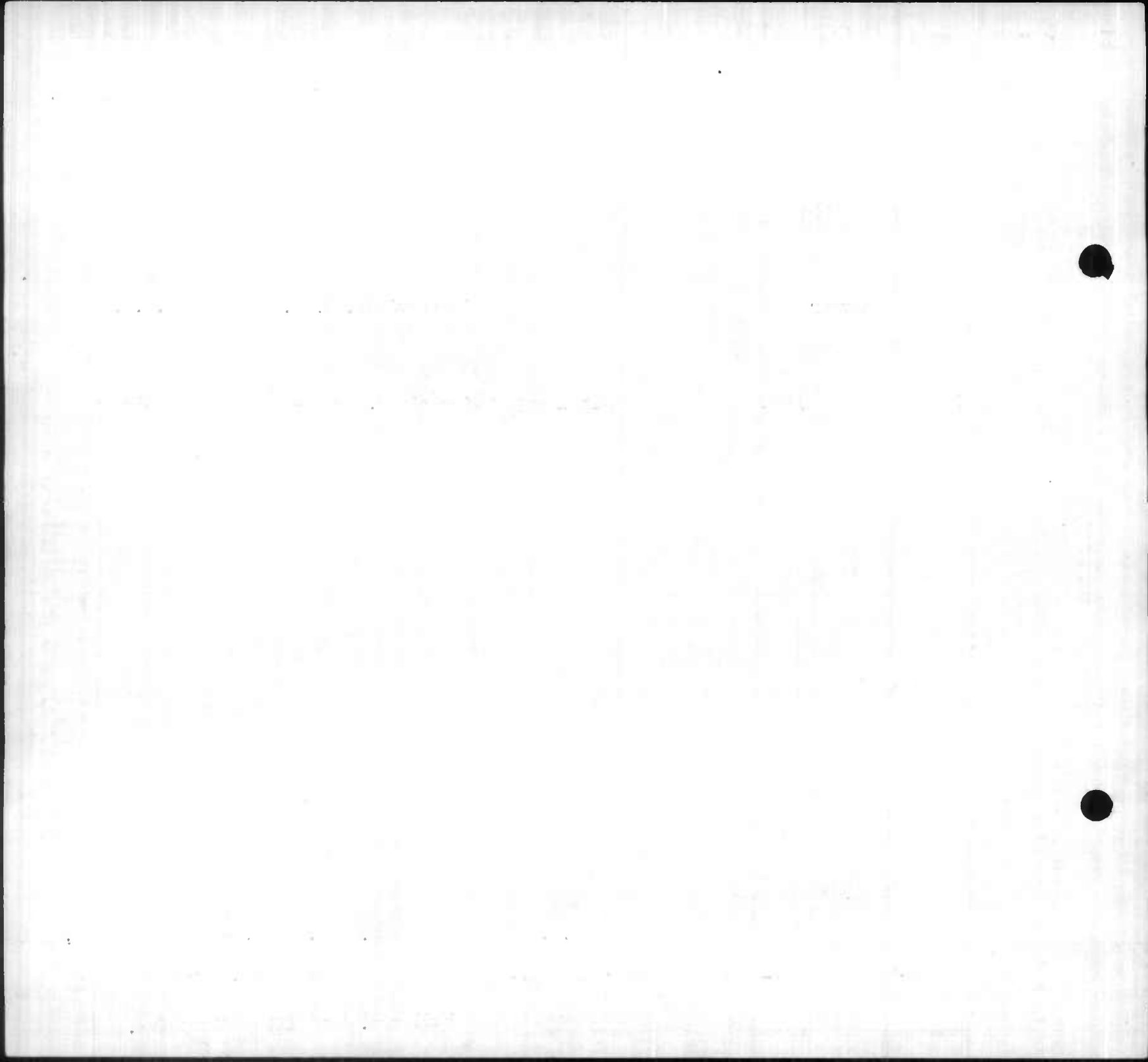


G. 600 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1110 | |
|---|-----------------|--|--------------------------|--|--|
| BIRTH NO. 65 1110 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) M. James Gray | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 2. DATE AND HOUR OF DEATH 1/28/65 5:30 p. M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY | |
| South Baltimore General Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 2830 Denham Circle | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 4/13/24 | 9. AGE (In years last birthday) 40 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Wintersville, N. C. | |
| 13. FATHER'S NAME James Gray | | 14. MOTHER'S MAIDEN NAME Jami Oaks | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 218-18-8521 | | 17. INFORMANT ADDRESS Virginia N. Gray - 2830 Denham Circle | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO Myocardial Infarction | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO HSCVD - Coronary | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/28/65 19 to 1/28/65 19 that (I) (we) last saw the deceased alive on 1/28/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael W. Kilchenstein M.D. | | | | 23B. DATE SIGNED 1/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL KILCHENSTEIN, M.D. | | | | 23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-2-65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) Baltimore, Maryland | | 24F. LOCATION (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. | |



65 1111

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1111

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SONNIE B. JEFFRIES

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1965

3:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3408 Holmes Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

6-17-1906

9. AGE (in years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mail Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Md. State Building

11. BIRTHPLACE (State or foreign country)

Raleigh, N. C.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Sonnie B. Jeffries

14. MOTHER'S MAIDEN NAME

Rebecca ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
215-03-4128

17. INFORMANT

ADDRESS

Pearl Jeffries - 3408 Holmes Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

DATE SIGNED
1/28/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-1-65

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

State

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

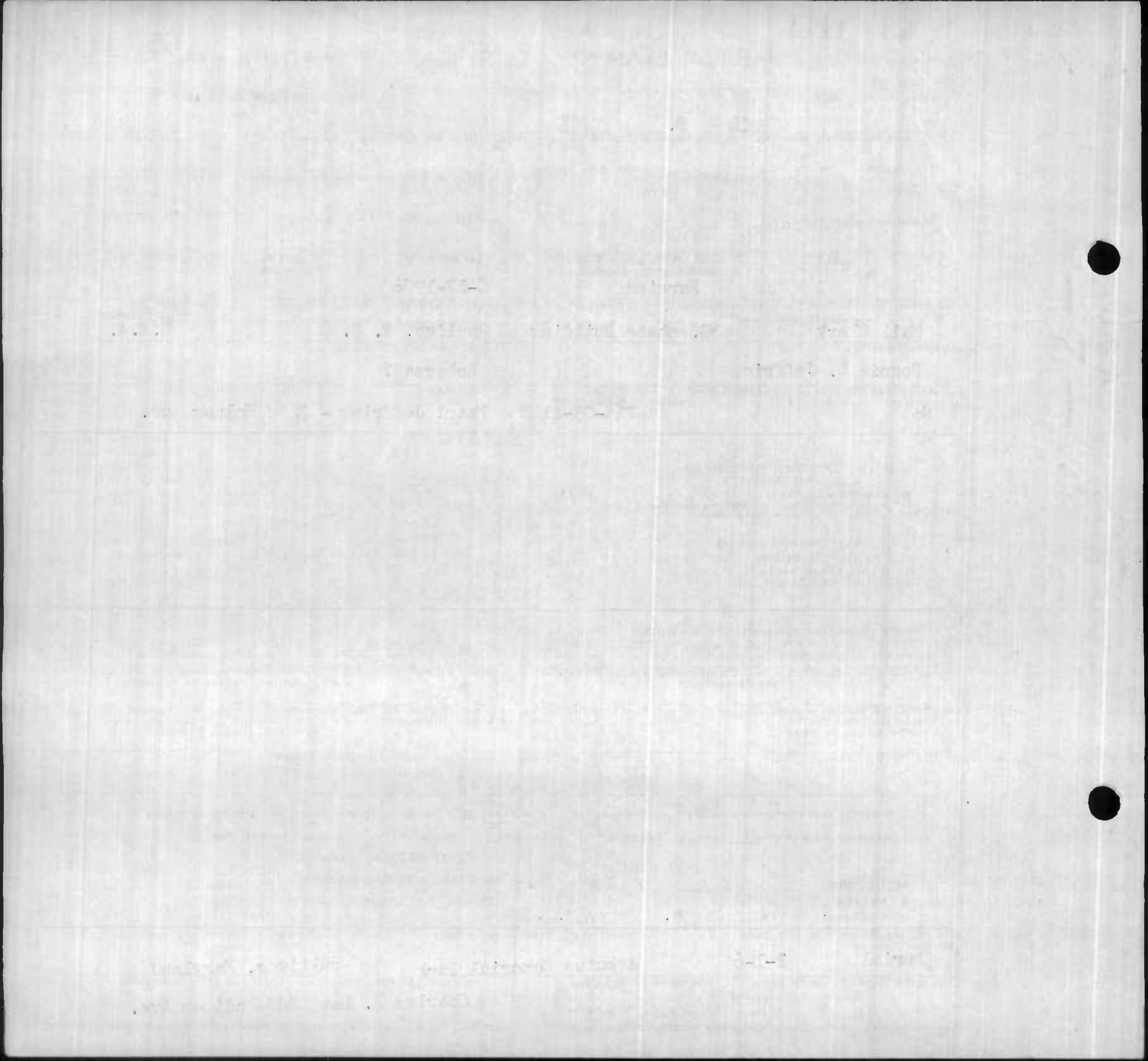
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

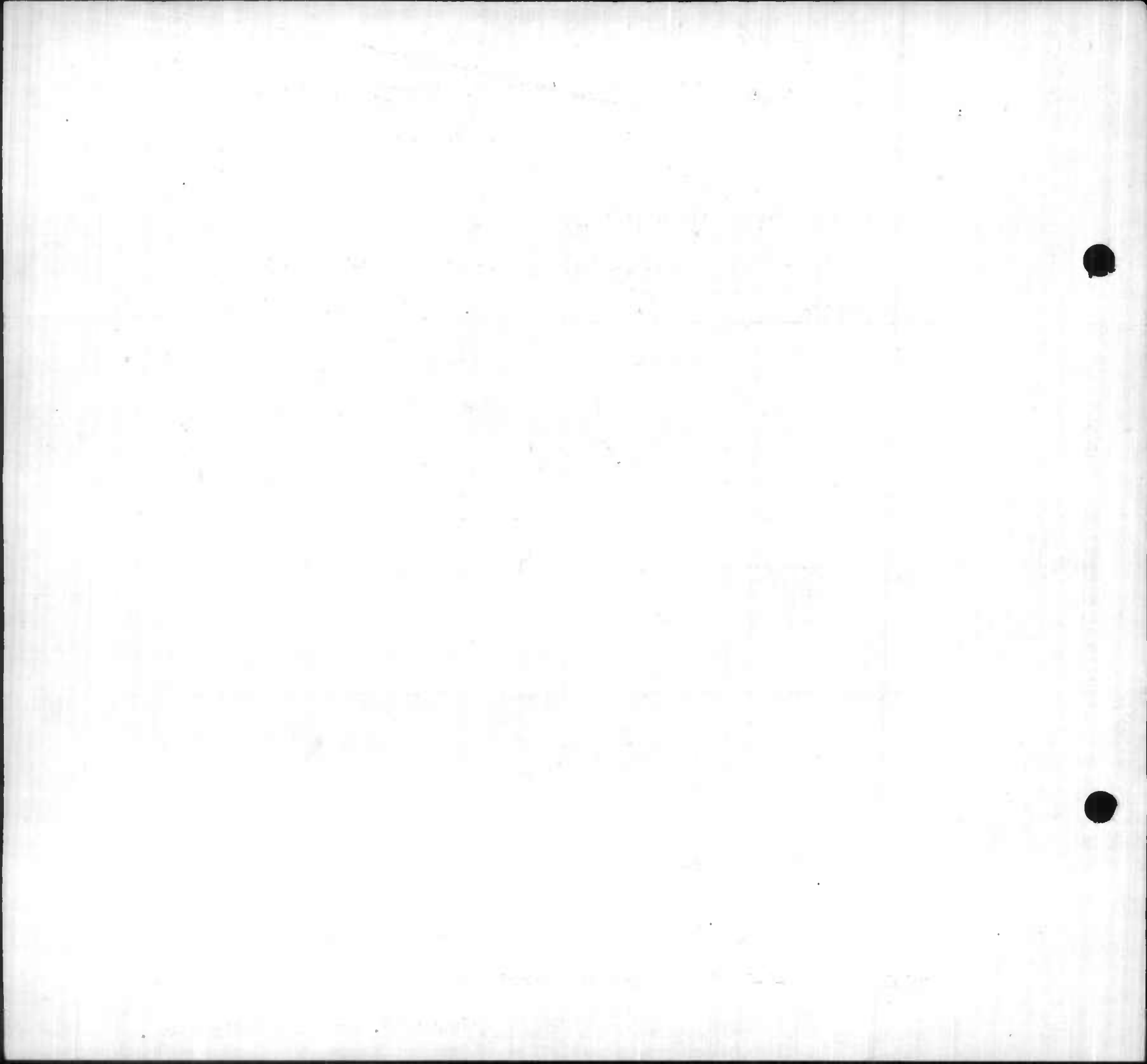
Charles R. Law 802 Madison Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1112 | |
|---|------------------|---|--|--|---------------------------------------|--|--|
| BIRTH NO. 65 1112 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ELIZA A. HARRIS (Eliza A. Stokes) | | 2. DATE AND HOUR OF DEATH JANUARY 28, 1965 9:45 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY BALTIMORE | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Geo Washington Carver Nursing Home 607 PENNSYLVANIA AVENUE BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 923 HARLEM AVENUE | | | | | |
| | | D. STREET ADDRESS (If rural, give location) 1601 | | | | | |
| 5. SEX F | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH Sept 12, 1899 | 9. AGE (In years last birthday) 65 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) So. Hampton Co., Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME THOMAS JONES | | | | 14. MOTHER'S MAIDEN NAME ANNIE DAVIS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NO | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT CHART# 607 | | ADDRESS 207 PENNSYLVANIA AVE | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Hypostatic Pneumonia DUE TO (B) Hypertensive card.-vasc. Disease DUE TO (C) Gen. Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 12 month Unknown Unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE E. E. Holt | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) E. E. Holt | | | | 23D. ADDRESS M.D. 3715 Liberty Hts. Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-2-1965 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. | | | |



M. 2¹36

65 1113

BALTIMORE CITY HEALTH DEPARTMENT

65 1113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)L.
Elmer Mixer, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 30, 1965

11:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3305 Hayward Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 22, 1904

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Guard, Md. State Dept. Motor Vehicles

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George T. Mixer

14. MOTHER'S MAIDEN NAME

Mamie Eaton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-05-8326

17. INFORMANT

ADDRESS

Mrs. E. L. Mixer, 3305 Hayward Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
Jan. 31, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/3/65

23C. NAME of CEMETERY or CREMATORY

Mt. Zion Cemetery

23D. LOCATION (City, town, or county)

Freeland, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

LaVerne Yemmon

ADDRESS

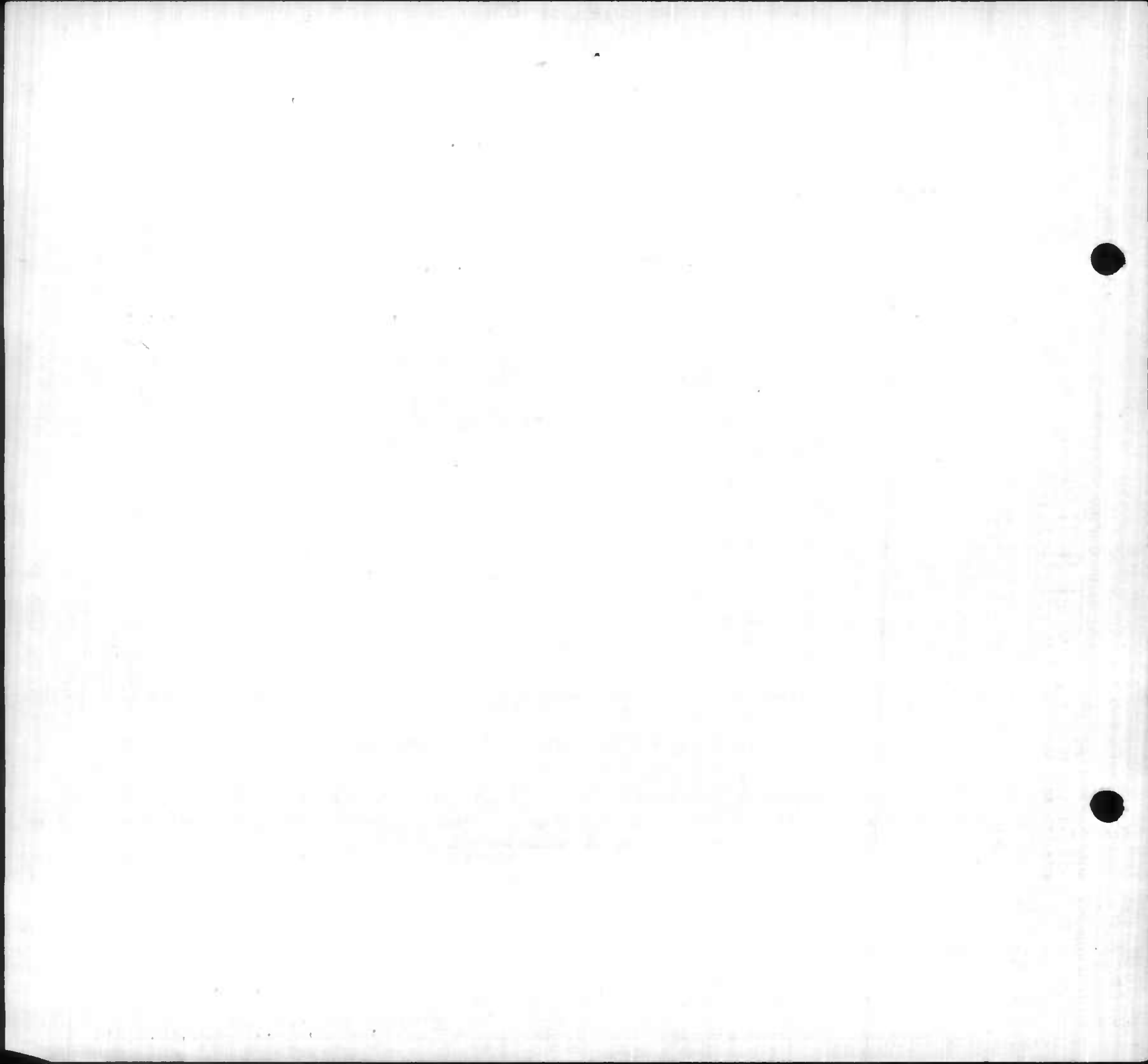
4611 Park Heights Ave.

WPA 1175 AND RGH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

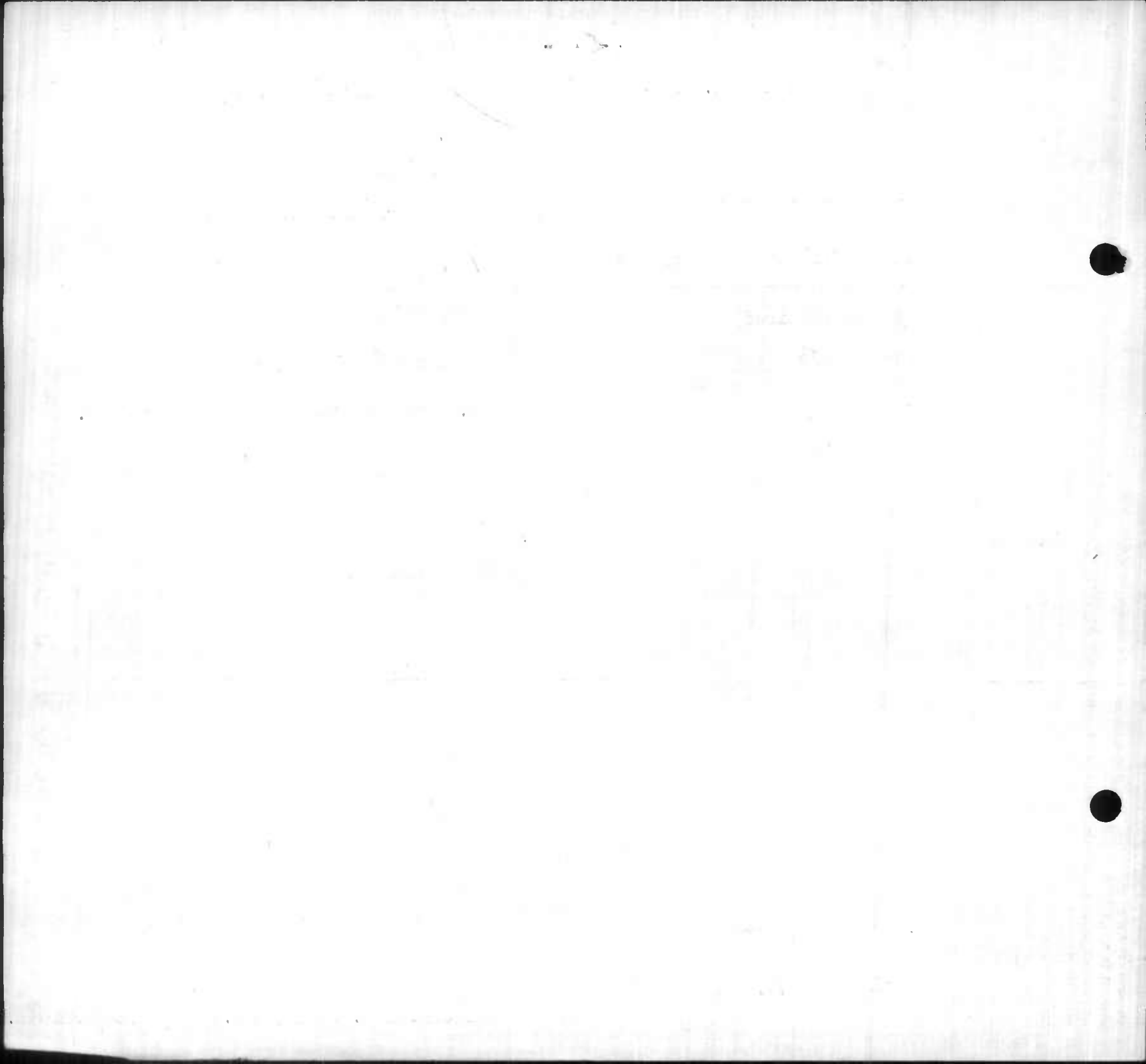
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1114 | |
|--|-------------------------|--|--|--|--|---|--|
| BIRTH NO. 65 1114 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | HARRY EDWARD ELGERT | | JANUARY 30, 1965 1:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1109 RAMBLEWOOD ROAD | | | | A. STATE MD. | | | |
| | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1109 RAMBLEWOOD ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH AUG. 6, 1880 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. GRAIN MERCHANT | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EDWARD ELGERT | | | | 14. MOTHER'S MAIDEN NAME ELLEN DAVIS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MISS THELMA ELGERT | | ADDRESS SAME | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Carcinoma of Stomach | | 3 months | |
| | | | | (B) Carcinoma of Prostate | | 12 yrs. | |
| | | | | (C) Pulmonary emphysema | | 5 yrs. | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 10 19 64 to Jan. 26 19 65 and that (I) (we) lost saw the deceased alive on Jan. 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Crawford N. Kirkpatrick, Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Jan. 30, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) CRAWFORD N. KIRKPATRICK, JR. | | | | 23D. ADDRESS 6 E. EAGER ST., BALTIMORE 2, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/2/1965 | | 24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. | | ADDRESS 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

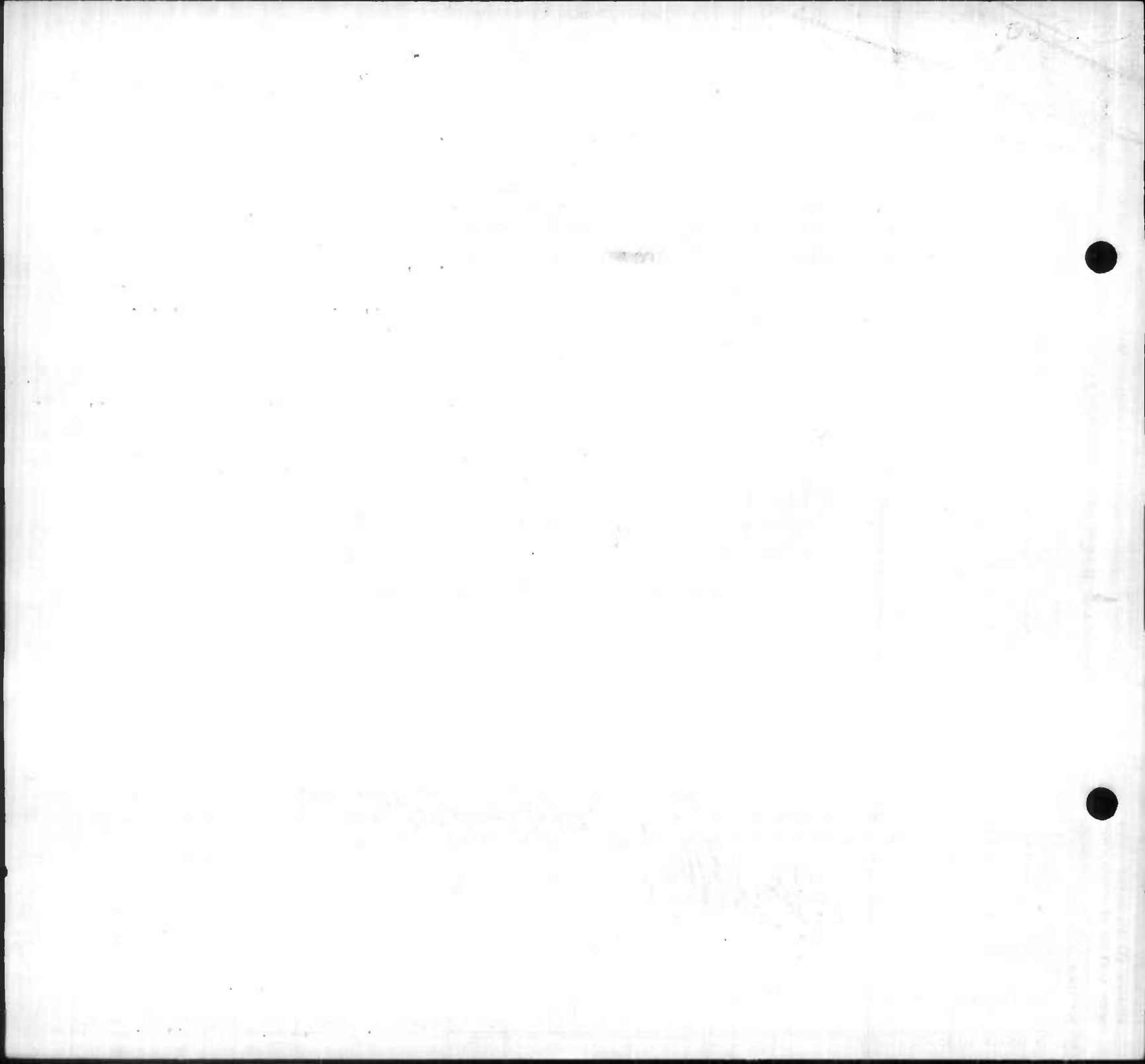
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1115 | |
|--|---|--|--|--|---|
| BIRTH NO. 65 1115 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) August H. Hemle | | 2. DATE AND HOUR OF DEATH January 29, 1965 6 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 27-07 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 6600 Old Harford Road | | D. STREET ADDRESS (If rural, give location) 6600 Old Harford Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/27/1880 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groceryman (Retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Jacob Hemle | | 14. MOTHER'S MAIDEN NAME Elizabeth Wildberger | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Dorothea Hemle 6600 Old Harford Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH Probable terminal Coronary thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Arteriosclerotic Coronary Disease | | (B) DUE TO Hypertension and Myocardial Hypertrophy | |
| | | (C) DUE TO due to arteriosclerosis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 10, 1937 to Jan 29, 1965 , that (I) (we) last saw the deceased alive on Jan 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (and not) view the body after death. | | | | | |
| 23A. SIGNATURE Vernon H. Norwood | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Jan 29, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Vernon H. Norwood, | | 23D. ADDRESS 5101 Woodside Road - 29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/2/1965 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

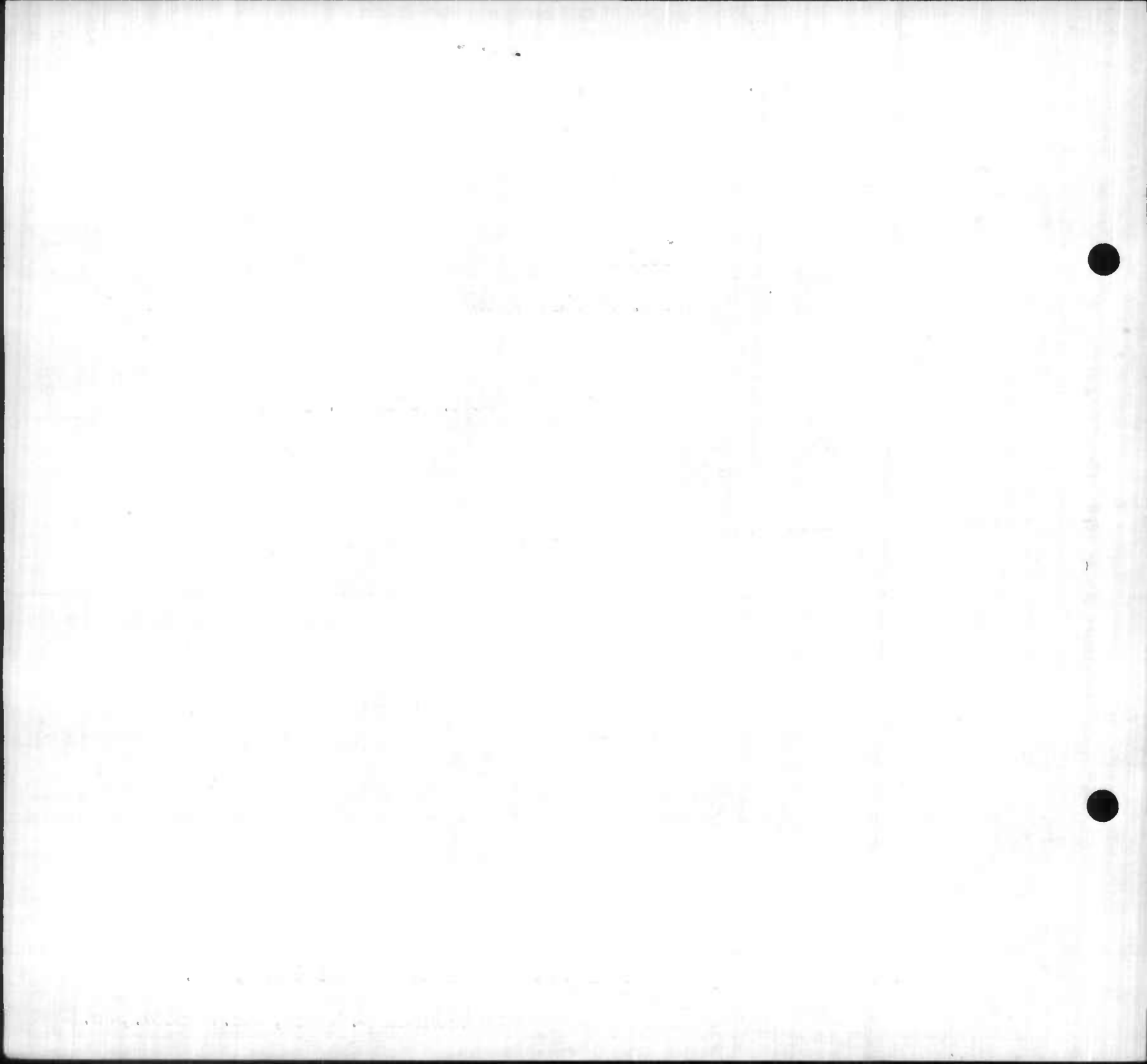
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1116 | |
|---|-------------------------|--|--|---|---|--|--|
| BIRTH NO. 65 1116 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) IRENE D. STREET T | | 2. DATE AND HOUR OF DEATH JANUARY 29, 1965 10:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GOULD CONVALESCENT HOME | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 8302 LOCH RAVEN BLVD. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH Sept. 2, 1893 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENRY MEYERS | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH BECK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. FRED POLLHAMMER, HEATHERHILL RD., MD. | | | |
| 18. 502.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Arteriosclerotic Heart Disease DUE TO (B) Cerebral Hemorrhage DUE TO (C) Chr. asthma, Bronchitis, Emphysema | | | | INTERVAL BETWEEN ONSET AND DEATH 4 mos 4 mos 20 yrs | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-18-1957 to 1-29-1965 that (I) (we) last saw the deceased alive on 1-29-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R. H. Silver | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) R. H. Silver | | | | 23D. ADDRESS 3105 N. Charles St. Balto. 18, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC. | | | |
| | | | | | | ADDRESS BALTO., MD. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|---|---|--|--|--|--|--|---------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1117 | | | | | |
| BIRTH NO. 65 1117 | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM C. FEHLEY | | | | | 2. DATE AND HOUR OF DEATH Jan - 29, 1965 6 10 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital | | | | | A. STATE Maryland COUNTY 26-09 | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| D. STREET ADDRESS (If rural, give location) 3704 Foster Avenue | | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 1/27/86 | 9. AGE (In years lost, birthday) 79 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Captain | | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Police Dept | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William J. Feehley | | | | | 14. MOTHER'S MAIDEN NAME Mamie? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Hilda B. Feehley | | ADDRESS Same | | | |
| 18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory + cardiac failure & CVA, @ hemisphere ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus | | | | | CAUSE OF DEATH | | | | | |
| | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 26 19 65 to Jan 28 19 65 , that (I) (we) last saw the deceased alive on Jan 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Nieva G. Valle | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED Jan. 29, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) NIEVA G. VALLE | | | | | 23D. ADDRESS Maryland General Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/2/65 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

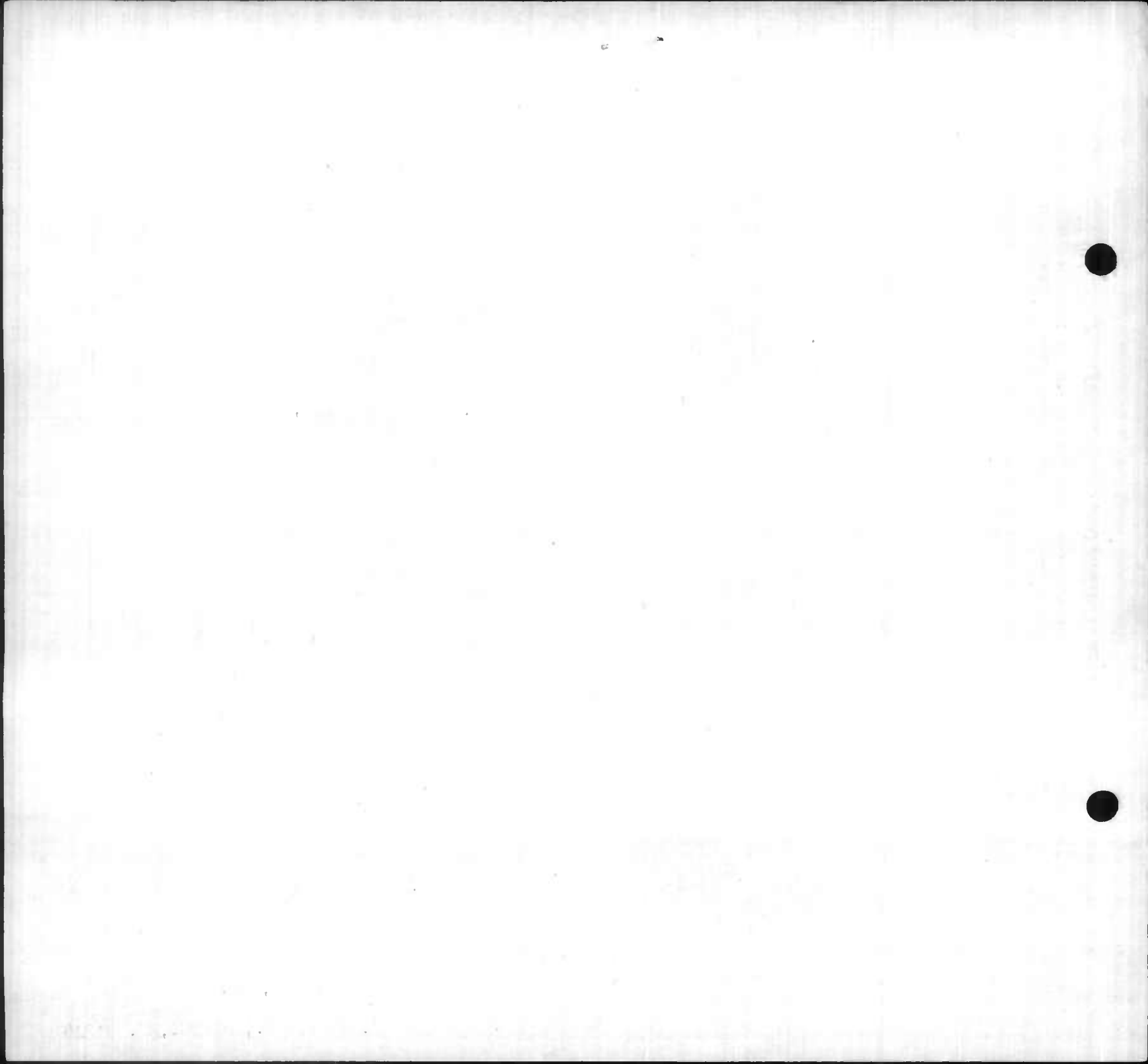
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1118 | |
|--|---|--|--|---|--|--|--|
| BIRTH NO. 65 1118 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | MARY A. GOLDSMITH | | JANUARY 29, 1965 8 35 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3014 GRINDON AVENUE | | | | A. STATE MD. | | | |
| | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3014 GRINDON AVENUE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | | 8. DATE OF BIRTH Oct. 28, 1870 | 9. AGE (In years last birthday) 94 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jacob Grimley | | | | 14. MOTHER'S MAIDEN NAME Susan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Cecile Goldsmith | | ADDRESS same | |
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Generalized arteriosclerosis DUE TO (B) Congestive Heart Failure DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 58 to 1/29 1965, that (I) (we) last saw the deceased alive on 1/28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Thomas L. Wansley Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 2-1-65 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Elmira, New York | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. | | ADDRESS 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1119 | |
|--|---------------------|--|--|--|--|--|--|--|-----------------------|--|--|
| BIRTH NO. 65 1119 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary Katherine Hill</i> (Kate) | | | | | 2. DATE AND HOUR OF DEATH <i>8:30 AM Jan 30. 65'</i> | | | | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Hospital for the Women of Maryland.</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>2705</i> | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>3208 Chesley Ave.</i> | | | | | | |
| 5. SEX <i>Fe</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i> | | | 8. DATE OF BIRTH <i>6/23/81</i> | 9. AGE (In years last birthday) <i>83</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | 13. FATHER'S NAME <i>Louis Hill</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Emma Bordealt (BORDEALT)</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT <i>MR. ELLSWORTH HILL,</i> | |
| | | | | | | | | | | ADDRESS <i>SAME</i> | |
| 18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) DUE TO <i>Myocardial infarction</i> (B) DUE TO (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 26</i> 19 <i>65</i> to <i>Jan 30</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Jan 30</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>O. Shen, M.D.</i> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <i>Jan 30. 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>I-SHEN. LiU, M.D.</i> | | | | | 23D. ADDRESS <i>Womens Hospital. Baltimore.</i> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | | 24B. DATE <i>2/2/1965</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY <i>WOODLAWN CEMETERY</i> | |
| | | | | | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i> | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1965</i> | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | | | | 25C. FUNERAL DIRECTOR <i>LEONARD J. RUCK, INC., BALTO., MD. 21214</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|--|---------------------------------------|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1120 | | | | |
| BIRTH NO. 65 1120 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MILDRED BLACKSTONE | | | | | 2. DATE AND HOUR OF DEATH 1/29/65 10 40 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | | | | A. STATE MARYLAND B. COUNTY A.A. COUNTY | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERN | | | | |
| D. STREET ADDRESS (If rural, give location) ROUTE 2 BOX 219 | | | | | | | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-14-18 | 9. AGE (In years last birthday) 46 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress | | | 10B. KIND OF BUSINESS OR INDUSTRY District Training Sch. | | 11. BIRTHPLACE (State or foreign country) Severn Md | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME CLARENCE QUEEN | | | 14. MOTHER'S MAIDEN NAME DAISY JONES | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hamilton Blackstone - Severn Md | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443X + 260X (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) Acute & Chronic Renal Insuffic. DUE TO (B) Arteriosclerotic Hypertensive C-V Dis. 15 yr and (C) Diabetes 30 yrs | | | INTERVAL BETWEEN ONSET AND DEATH ? 5 yrs. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/14 19 65 to 1/29 19 65, that (I) (we) last saw the deceased alive on 1/29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Willis C. Maddrey | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/29/65 | | |
| 23C. PHYSICIAN'S NAME (Type) Willis C. Maddrey | | | | | 23D. ADDRESS Johns Hopkins Hosp. Balt. Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk | | 24D. LOCATION (City, town, or county) (State) Arbutus Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR Gurnell & Son - Balt. Md | | | |



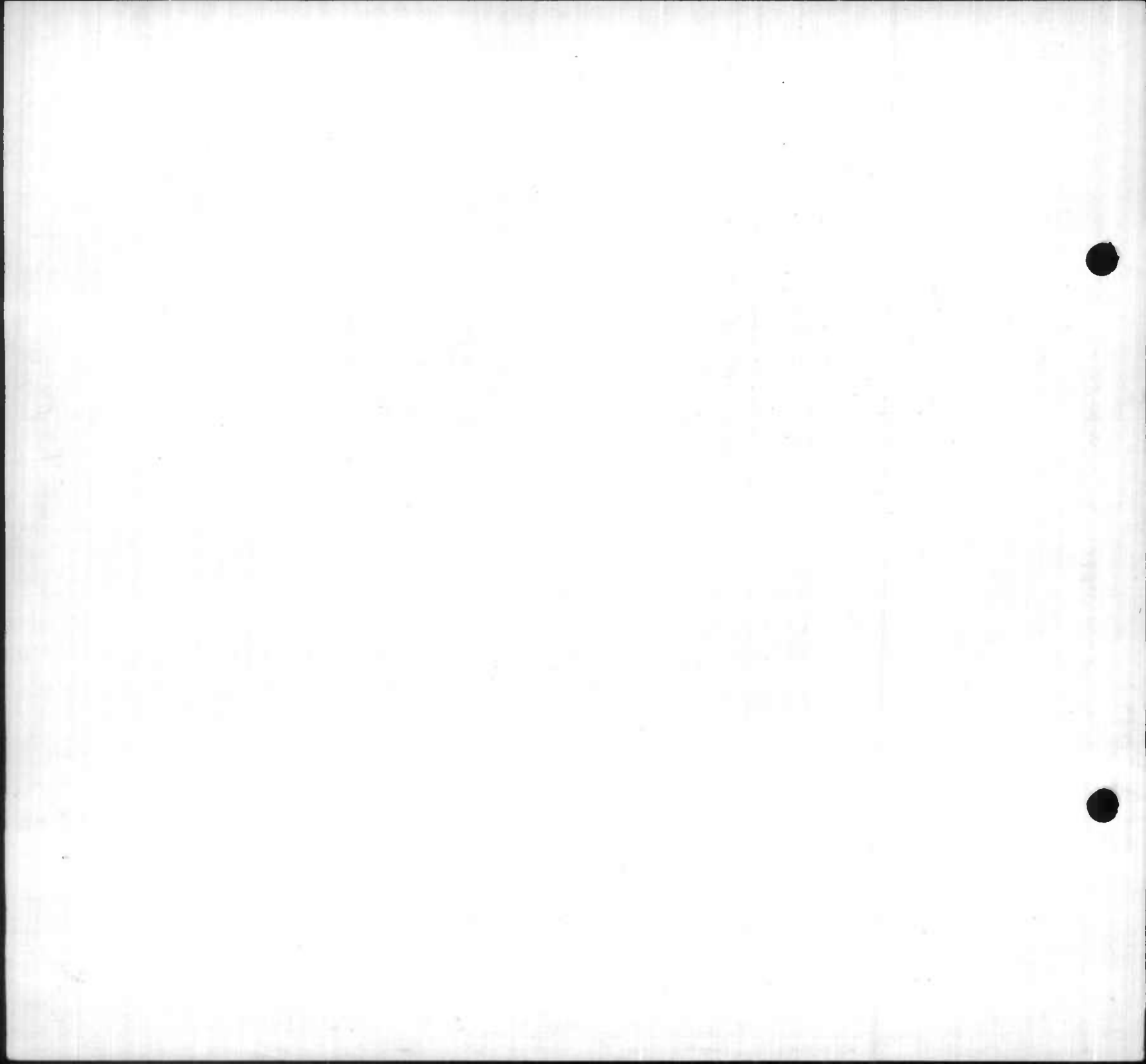
UNION PAC RAILROAD



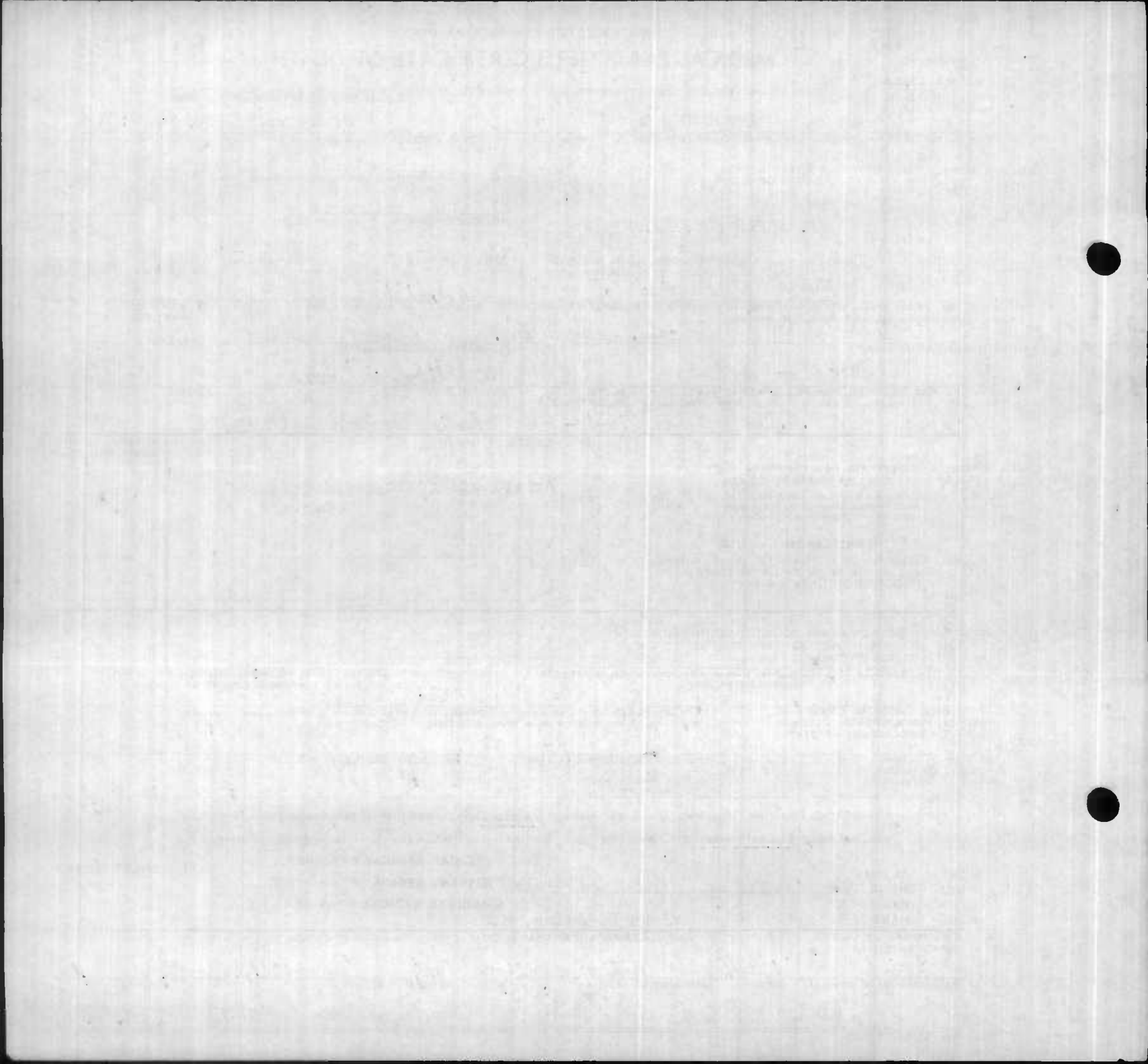
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1121 | |
|--|---------------------|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 65 1121 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) GORDON - MAGGIE | | | | | | 2. DATE AND HOUR OF DEATH 1/28/65 - 12.30 PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI - HOSPITAL | | | | | | A. STATE MD B. COUNTY 15.48 | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) SCOTTS - NURSING HOME 2305 ROSCYN | | | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) T | | 8. DATE OF BIRTH 3-98-1891 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Va | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wm Harmon | | | | | | 14. MOTHER'S MAIDEN NAME Mary Harmon | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT James Savage - Severn, MD | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 1) BRONCHOPNEUMONIA - 2) CVA - 3) DIABETIC ACIDOSIS - 2 DO TO ASCVD - 3) DIABETES - MELLITUS | | | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II DIABETES - MELLITUS | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27/65 19 to 1/28/65 19 that (I) (we) last saw the deceased alive on 1/28/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE A. Ary | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> A. Ary | | | | 23B. DATE SIGNED 1/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) ARON - ARY | | | | | | 23D. ADDRESS SINAI - HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 2-1-65 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK | | | | 24D. LOCATION (City, town, or county) (State) Arbutus MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | | | 25C. FUNERAL DIRECTOR Purcell S. Oden - Balto. Md. | | | |



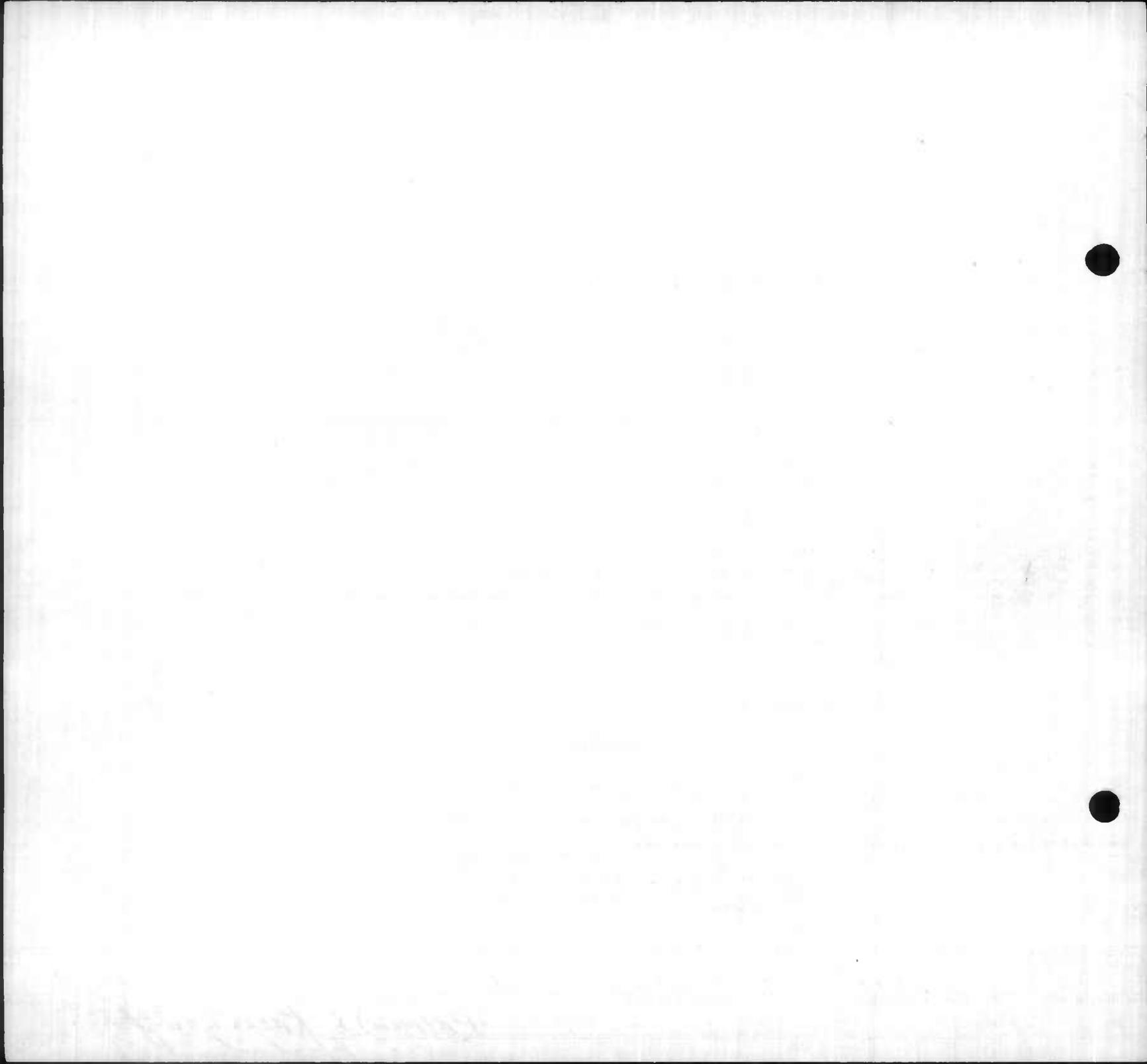
| BIRTH NO. | | 65 1122 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 65 1122 | |
|---|--|--|--|---|--|--|--|---------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | | | |
| LEON GOODNOW | | | | January 25, 1965 9:04 A. M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | | | |
| ST. AGNES HOSPITAL | | | | Maryland | | Baltimore | | 153-00 | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | Box 5845 Old Court Road | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Male | | White | | Married | | June 8, 1918 | | 46 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Bricklayer | | | | Consolid. Masonry Ins. | | New Jersey | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Percy Goodnow | | | | Edizabeth Goodnow | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes W.W.II | | | | 216-12-6848 | | Family Records | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | | | |
| Arteriosclerotic cardiovascular disease | | | | | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | Yes | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| John E. Adams | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 1-26-65 | |
| John E. Adams, M.D. | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 1/29/65 | | Baltimore National Cem. | | Catonsville, Maryland | | | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | | | | | |
| FEB 1 1965 | | Robert E. Farley, M.D. | | John Burns Sons 610-12 York Rd. Towson | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1123 | |
|--|---|---|--|--|--|--|--|
| BIRTH NO. 65 1123 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANNA Henneberry | | | | 2. DATE AND HOUR OF DEATH 1-31-65 10:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor 1200 Valley St Baltimore Md 21202 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk D. STREET ADDRESS (If rural, give location) 1922 Denberry Dr. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) | | 8. DATE OF BIRTH Dec. 25, 1873 | 9. AGE (In years last birthday) 92 | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John McGurrian | | | | 14. MOTHER'S MAIDEN NAME MARY DOLAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 052-01-8102 | | 17. INFORMANT ADDRESS Little Sisters of the Poor - 1200 Valley St. | | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral accident - stroke. Generalized arteriosclerosis. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to Jan 31 19 65 , that (I) (we) last saw the deceased alive on Jan 31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Stanley Ankudas | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. Stanley Ankudas | | | | 23D. ADDRESS M.D. 1802 W. Baltimore St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-5-65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross | | 24D. LOCATION (City, town, or county) (State) New York N. Y. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS RAYMOND L. KACZOROWSKI 2525 Fleet St #34 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 65 1124 Registered No. 65 1124

M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JAMES Sampson

2. DATE AND HOUR OF DEATH 29 January 1965 12:00 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 20-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2420 Lauretta Ave.

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH 4/20/1898 9. AGE (In years last birthday) 66

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Repair MAN 10B. KIND OF BUSINESS OR INDUSTRY CONTRACTING

11. BIRTHPLACE (State or foreign country) ST. MARY'S COUNTY, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Thomas Sampson 14. MOTHER'S MAIDEN NAME MARY BUTLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 218-10-4771

17. INFORMANT ADDRESS MARY E. BROWN 2420 Lauretta Ave; Balto, Md.

18. 304X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Pneumonia (B) Brain Syndrome (C) Dehydration INTERVAL BETWEEN ONSET AND DEATH 2 days 2 Few days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

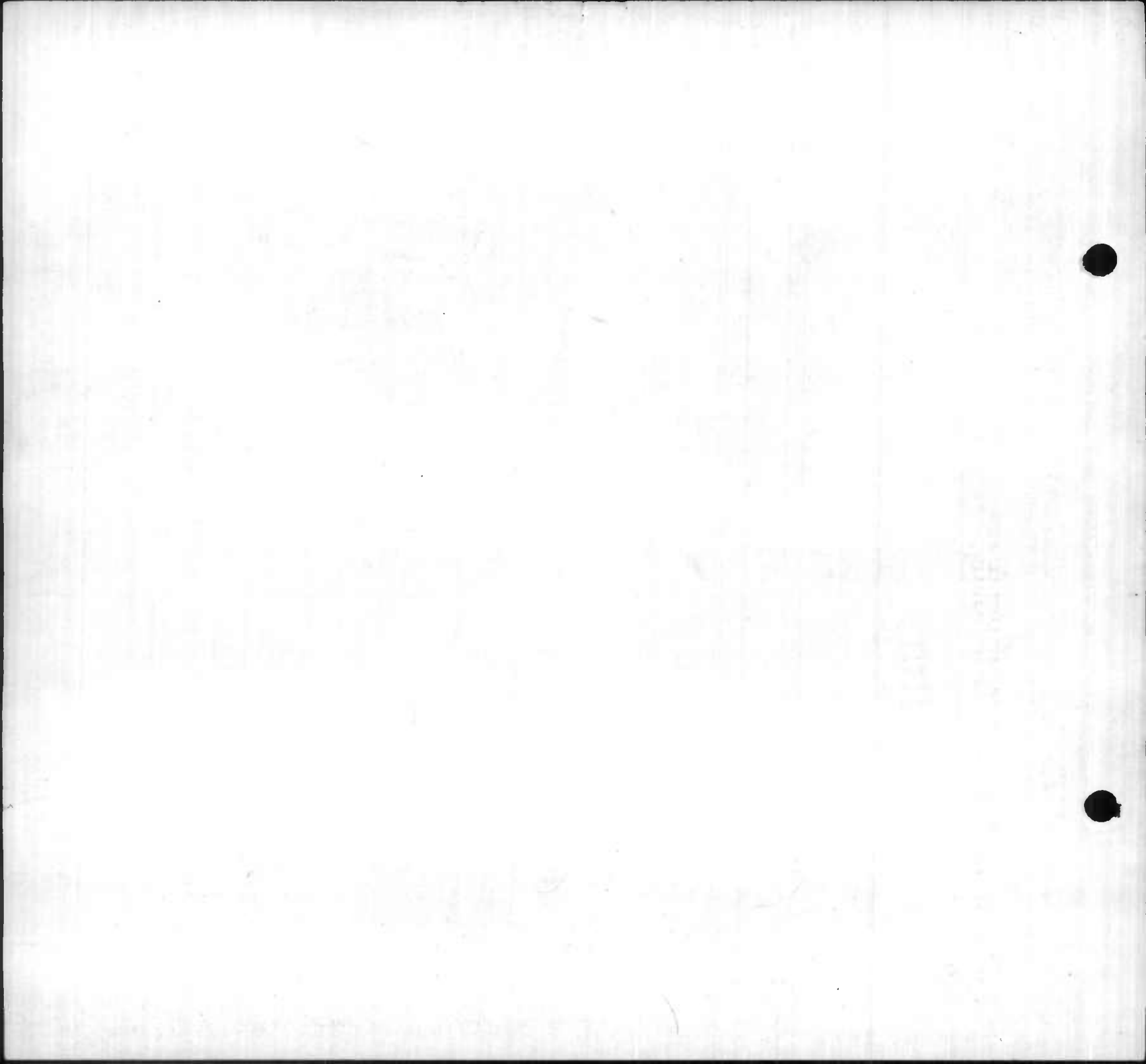
22. I certify that (I) (this hospital) attended the deceased from Nov 20 1965 to 1-29 1965, that (I) (we) last saw the deceased alive on 1-29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [Signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED 29 JANUARY 1965

23C. PHYSICIAN'S NAME (Type) [Signature] M.D. 23D. ADDRESS 403 Med Arts Bldg

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE Burial Feb 2, 1965 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn 24D. LOCATION Balto Md.

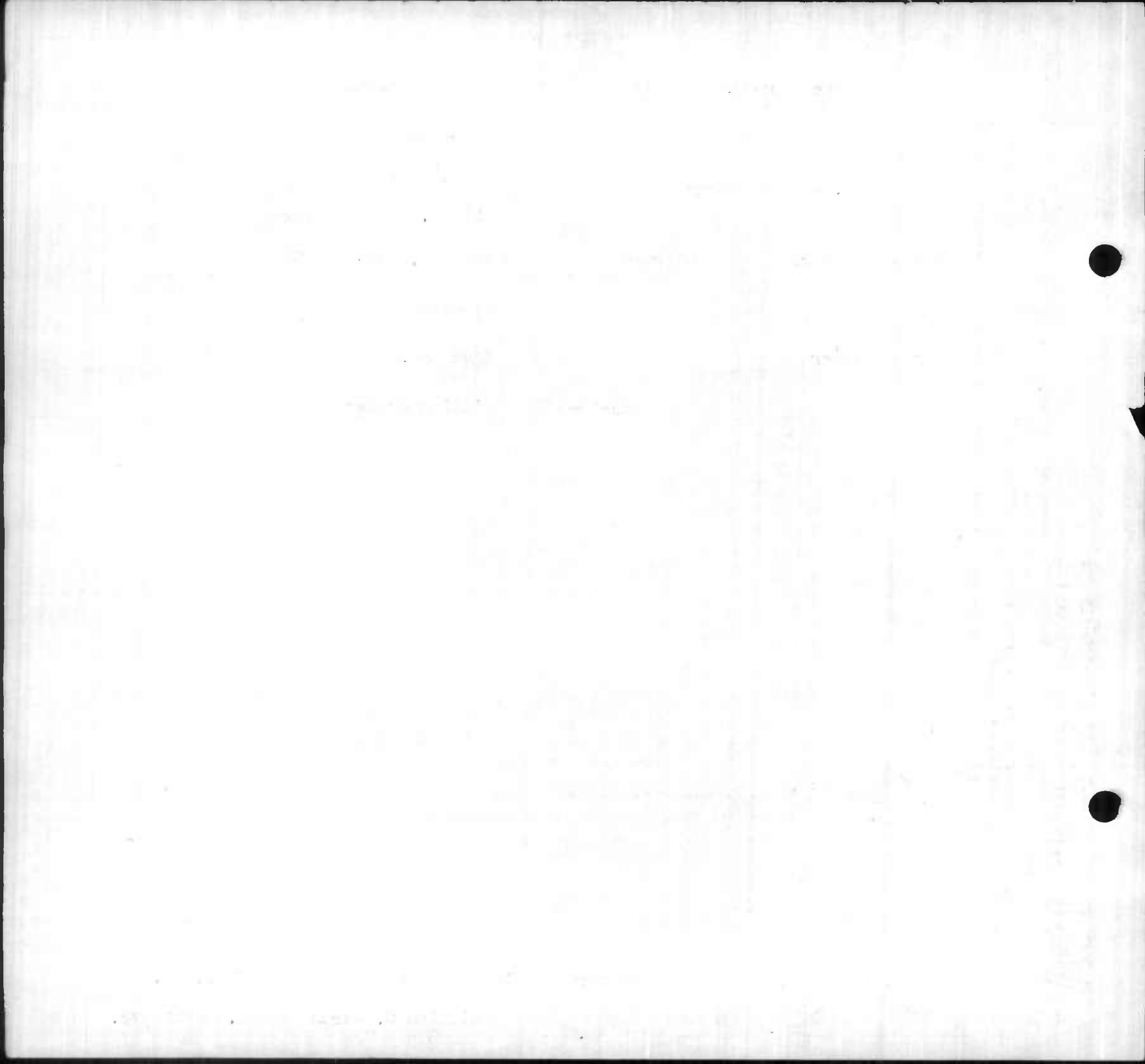
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 25B. NAME OF REGISTRAR Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR ADDRESS Holland Funeral Home 1631 Druid Hill Ave. Balto., Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

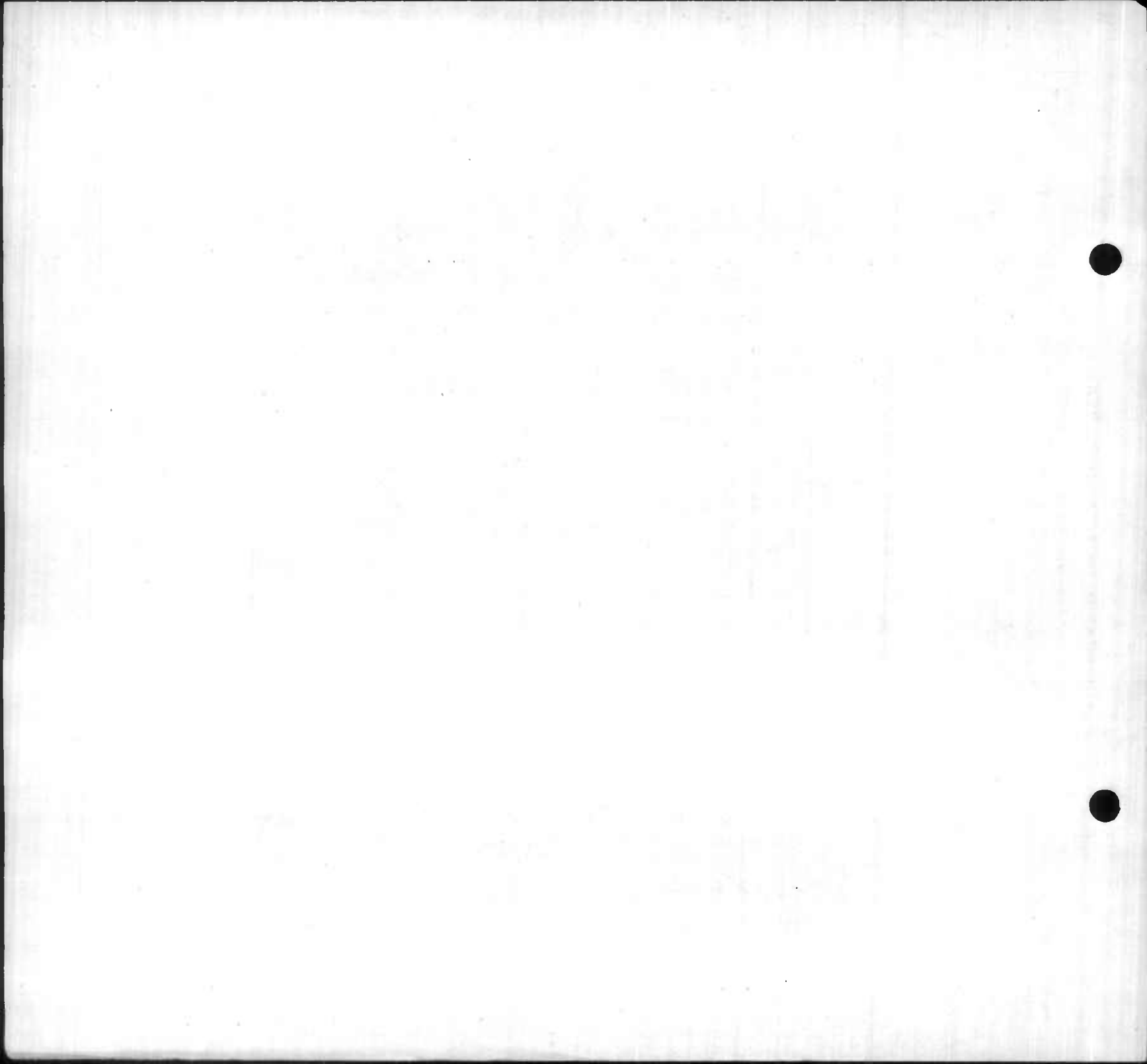
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1125 | |
|---|-------------------------|--|--|---|--|
| BIRTH NO. 65 1125 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Rose (Rosetta) Parker | | | | 2. DATE AND HOUR OF DEATH 1-27-65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 410 N. Calhoun Street | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 19-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 410 N. Calhoun Street | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH April 6, 1888 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia |
| 13. FATHER'S NAME Frank Fuller | | | 14. MOTHER'S MAIDEN NAME Inez Epps | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 113-20-3538 | | 17. INFORMANT Lillian Fuller |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1-20-0 I Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 Days | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 21. INTERVAL BETWEEN ONSET AND DEATH 2 Days | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-23-1965 to 1-27-1965 , that (I) (we) last saw the deceased alive on 1-26-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard H. Hunt | | | | 23B. DATE SIGNED 1-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) Richard H. Hunt | | | | 23D. ADDRESS 1607 W. Mulberry St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Ann Arundel Cty., Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR William C. March | | | |
| 25D. ADDRESS 928 E. North Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. <u>65 1126</u> | |
|--|--|--|--|---|--|
| BIRTH NO. <u>65 1126</u> | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>January 29, 1965</u> <u>4.00 P.M.</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM COOK</u> | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1602 Lewelyn Ave.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>8-07</u> | | |
| 5. SEX <u>male</u> | | | 6. RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u> |
| 8. DATE OF BIRTH <u>Feb. 4, 1889</u> | | 9. AGE (In years last birthday) <u>75</u> | | 10. AGE (In years last birthday) <u>75</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Salesman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>John A. Cook</u> | | 14. MOTHER'S MAIDEN NAME <u>Virginia Washburn</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Mrs. Anna Mae Cook.</u> <u>1602 Lewelyn Ave. Baltimore Md. 21213</u> | |
| 18. <u>422.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic myocarditis & myocardial degeneration</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/26/65</u> <u>11:00</u> to <u>1/26</u> <u>1965</u> that (I) (we) last saw the deceased alive on <u>1/26/65</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert E. Taylor</u> | | | | 23B. DATE SIGNED <u>1/30/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>STANENBAM</u> | | | | 23D. ADDRESS <u>1100 E. 11th Ave</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>Feb. 1, 1965</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u> | |
| 24D. LOCATION <u>Baltimore Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> | | 25D. ADDRESS <u>Baltimore Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-1631

BIRTH NO. 65 1127

CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 65 1127

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Seibert, Creta Carolyn

2. DATE AND HOUR OF DEATH 1/30/65 5:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY 1-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 325 S. Ellwood Avenue

5. SEX Female

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single

8. DATE OF BIRTH 6/9/1896

9. AGE (In years last birthday) 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel D. Seibert

14. MOTHER'S MAIDEN NAME Nellie B. Long

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 215-18-8404

17. INFORMANT MRS GEORGETTE ECK 325 S. ELLWOOD Hospital Records AVENUE 21224

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/28/65 19 to 1/30/65 19, that (I) (we) last saw the deceased alive on 1/30/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Daniel G. Lai

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 1/30/65

23C. PHYSICIAN'S NAME (Type) Daniel G. Lai

23D. ADDRESS 2201 Argonne Drive, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 2/1/65

24C. NAME OF CEMETERY or CREMATORY PARKWOOD

24D. LOCATION (City, town, or county) (State) Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965

25B. NAME OF REGISTRAR Robert E. Farley

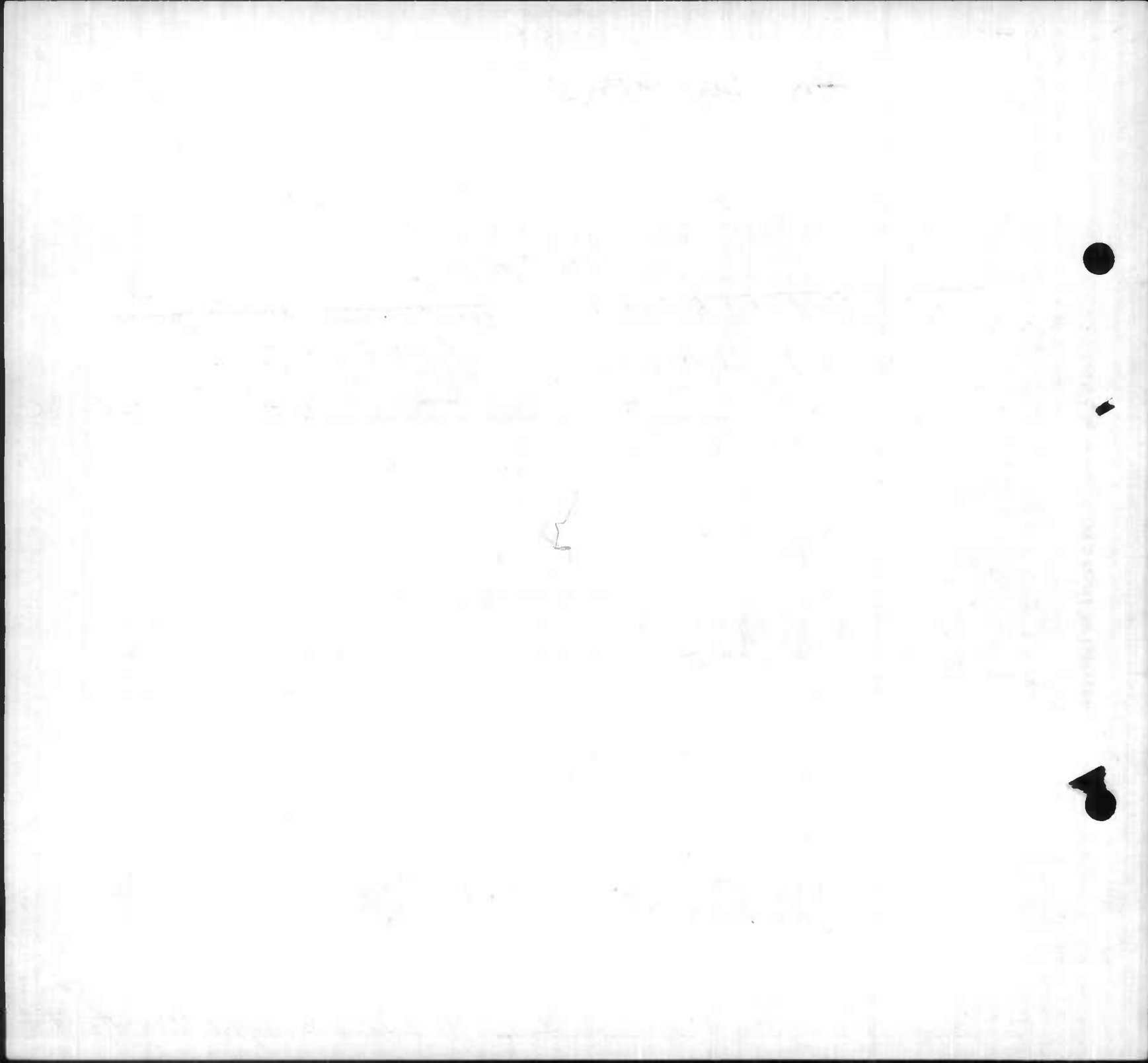
25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND

10/10/1914
G. H. [unclear]
[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

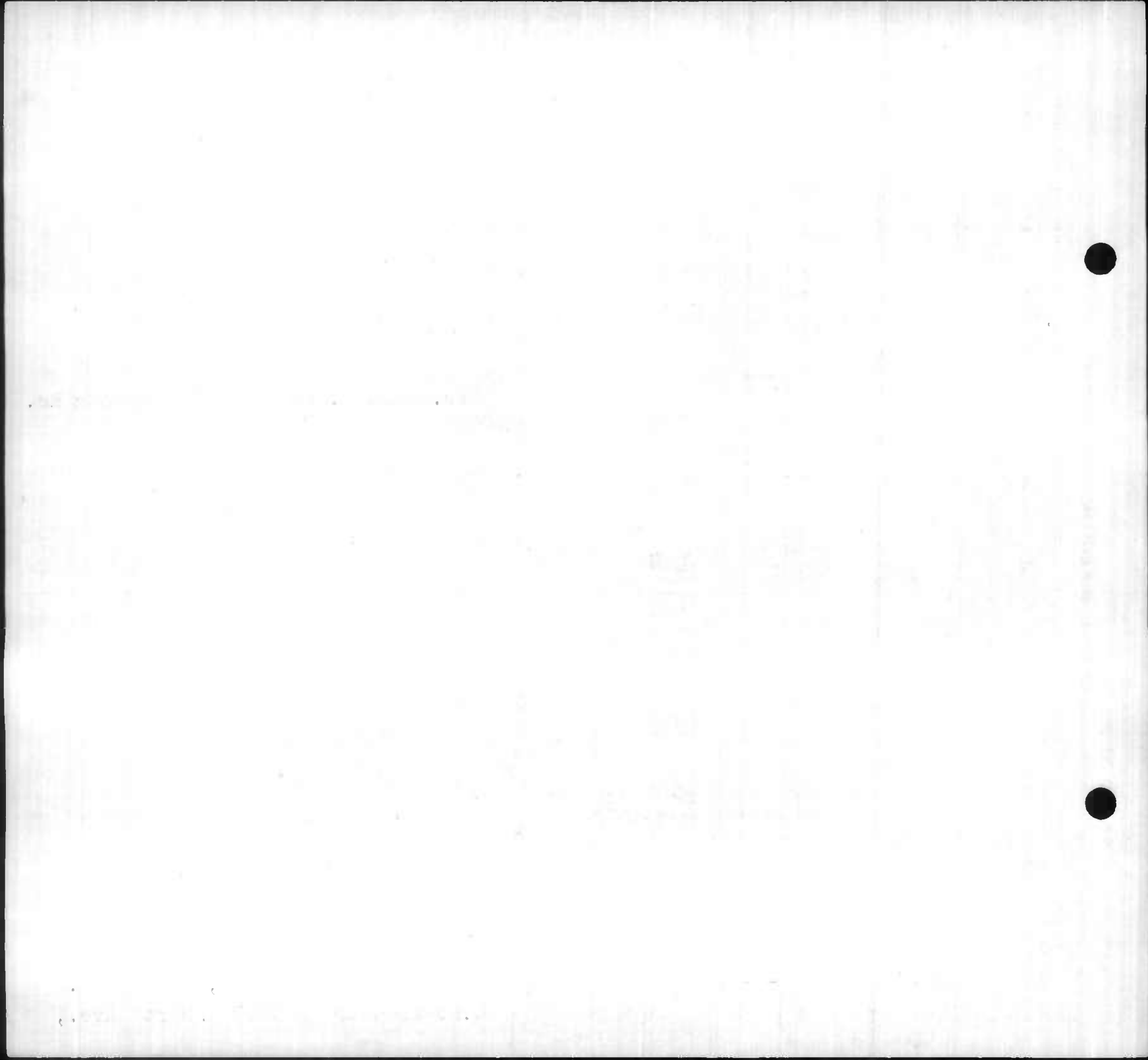
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|---------------------|---|--|--|--|---|--|--|--|---|--|
| BIRTH NO. 65 1128 | | Registered No. 65 1128 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) AIRY SUMMERS | | | | | | 2. DATE AND HOUR OF DEATH 8:25 p.m. Jan/27/65 M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 17-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 416 W. Good St. Greed | | | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W separated | | 8. DATE OF BIRTH August 31, 1903 | | 9. AGE (In years last birthday) 61 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur and Laborer | | 11. BIRTHPLACE (State or foreign country) Westminster Carroll Co. Md. | |
| 13. FATHER'S NAME Thomas Summers | | | | | | 14. MOTHER'S MAIDEN NAME ANNIE Diggs | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | | | | 16. SOCIAL SECURITY NO. 220-09-9907 | | 17. INFORMANT Mrs. John A. Trist Charles E. Westminster Md. | | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Registrom heart Cardiac Vascular Hemorrhage. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/6/65 19 65 to 1/27/65 19 65 and that (I) (we) lost saw the deceased alive on 1/27/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John William Eckholdt | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) John William Eckholdt | | | | | | 23D. ADDRESS Univ Hosp. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/31/65 | | 24C. NAME of CEMETERY or CREMATORY St. James Cemetery | | 24D. LOCATION (City, town, or county) (State) New Windsor Rd. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR J. S. Myers Jr., Westminster Md. | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|---------------------------------------|---|--|
| BIRTH NO. 65 1129 | | CITY HEALTH DEPARTMENT | | REGISTERED NO. 65 1129 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 1. NAME OF DECEASED (Type or Print) Schetlich HERMAN | |
| 2. NAME OF DECEASED (Type or Print) | | 3. DATE AND HOUR OF DEATH JANUARY 30 1965 5 AM | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital | | D. STREET ADDRESS (If rural, give location) 1101 W Baltimore | | E. AGE (In years last birthday) 71 | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 11-14-1893 | 9. AGE (In years last birthday) 71 | 10. UNDER 1 Yr. Months Days 11-14-1893 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanics | | 10B. KIND OF BUSINESS OR INDUSTRY Telephone Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Schetlich Frederick | | 14. MOTHER'S MAIDEN NAME Kaabe DORA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-03-6953 | | 17. INFORMANT ADDRESS Mrs. James A. Barone 3611 Langrehr Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 157X I | | CAUSE OF DEATH (A) Carcinoma of the Pancreas (B) Esophagus (C) Obstructive jaundice | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22. DATE OF OPERATION | | 23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 26. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 28. I certify that (I) (this hospital) attended the deceased from 1-17 1965 to 1-30 1965 , that (I) (we) last saw the deceased alive on 1-30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 29. SIGNATURE Amelino M. Celligro M.D. | | 30. DATE SIGNED 1/30/65 | |
| 31. PHYSICIAN'S NAME (Type) Amelino M. Celligro M.D. | | 32. ADDRESS N. Charles Gen. Hospital | | 33. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | |
| 34. NAME OF CEMETERY OR CREMATORY Burial | | 35. DATE 2-2-1965 | | 36. NAME OF REGISTRAR Robert E. Fisher M.D. | |
| 37. LOCATION (City, town, or county) (State) Baltimore, Md. | | 38. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave., | | 39. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | |



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

JAMES E. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1965 10:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

687 Pierce St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

687 Pierce St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 25, 1902

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Lee McMener

17 N. Pine Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Air embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Incised wound of neck
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

687 Pierce St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 27 65 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Self inflicted incised wound of neck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

1-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-31-1965

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

(City, town, or county)

Arbutus, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

N874, FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

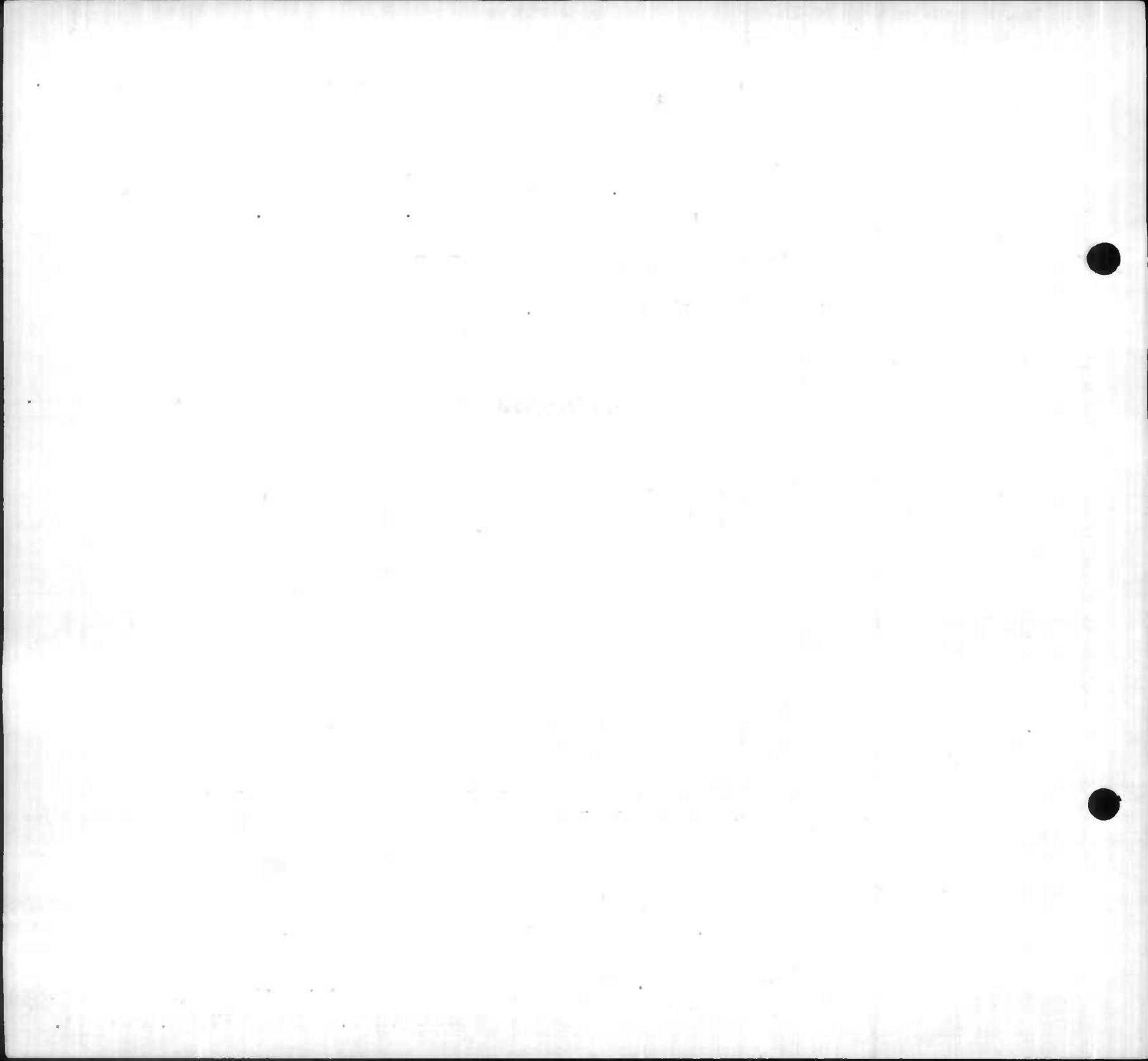
Arlington S. Phillips 1727 N. Monroe St.

WALTER FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1131 | |
|--|---------------|--|-----------------------------|--|--|
| BIRTH NO. 65 1131 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Carroll, William | |
| 2. DATE AND HOUR OF DEATH 1-25-65 8:00 a.m. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| Provident Hospital 1514 Division St. Baltimore, Maryland 21217 | | A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1138 N. Stricker St. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-13-1882 | 9. AGE (In years last birthday) 82 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-01-9370 | |
| 17. INFORMANT (wife) Mary Carroll 1138 N. Stricker St. | | 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Cerebral Hemorrhage | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-17-65 19 to 1-25-65 19, that (I) (we) last saw the deceased alive on 1-25-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED 1-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) Ruperto M. Manankil | | | | 23D. ADDRESS 1514 Division St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-29-1965 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION A.A. Co., Maryland | | 24E. NAME OF REGISTRAR Robert E. Taylor | | 24F. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe St. | |



R 534

65 1132

BALTIMORE CITY HEALTH DEPARTMENT

65 1132

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|---|---|--|--|---|------------------------------|
| 1. NAME OF DECEASED (Type or Print) HEZEKIAH RANDALL | | | | 2. DATE AND HOUR PRONOUNCED DEAD January 27, 1965 7:20 P. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2301 Avalon Avenue | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married Searated | 8. DATE OF BIRTH May 12, 1895 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Richmond, Virginia | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 215-09-1313 | | 17. INFORMANT ADDRESS Howard Jones 4716 Renwood Ave. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 422.1 I Arteriosclerotic Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. EXAMINER'S NAME (Type) Charles S. Petty, M.D. DATE SIGNED 1/28/65 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2-1-1965 | | 23C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 23D. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St. | | | |

WALLACE JOHNSON

F260

65 1133

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1133

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY FISHER

2. DATE AND HOUR PRONOUNCED DEAD

January 31, 1965

3:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3448 Reisterstown Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

JAN 15 1889

9. AGE (In years
last birthday)

70 76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

POSTAL EMPLOYEE, RET.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

LITHUANIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ISAAC

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

HOSPITAL RECORDS, BALTIMORE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Craniocerebral injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1-25-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head injury

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3448 Reisterstown Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 25 65 7:15
P.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell down back steps

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-31-65

23C. NAME OF CEMETERY or CREMATORY

ROSEDALE

23D. LOCATION

(City, town, or county)

BALTIMORE

Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

1856-2 FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Gaed Lewis Inc 2100 Eutaw Pl.

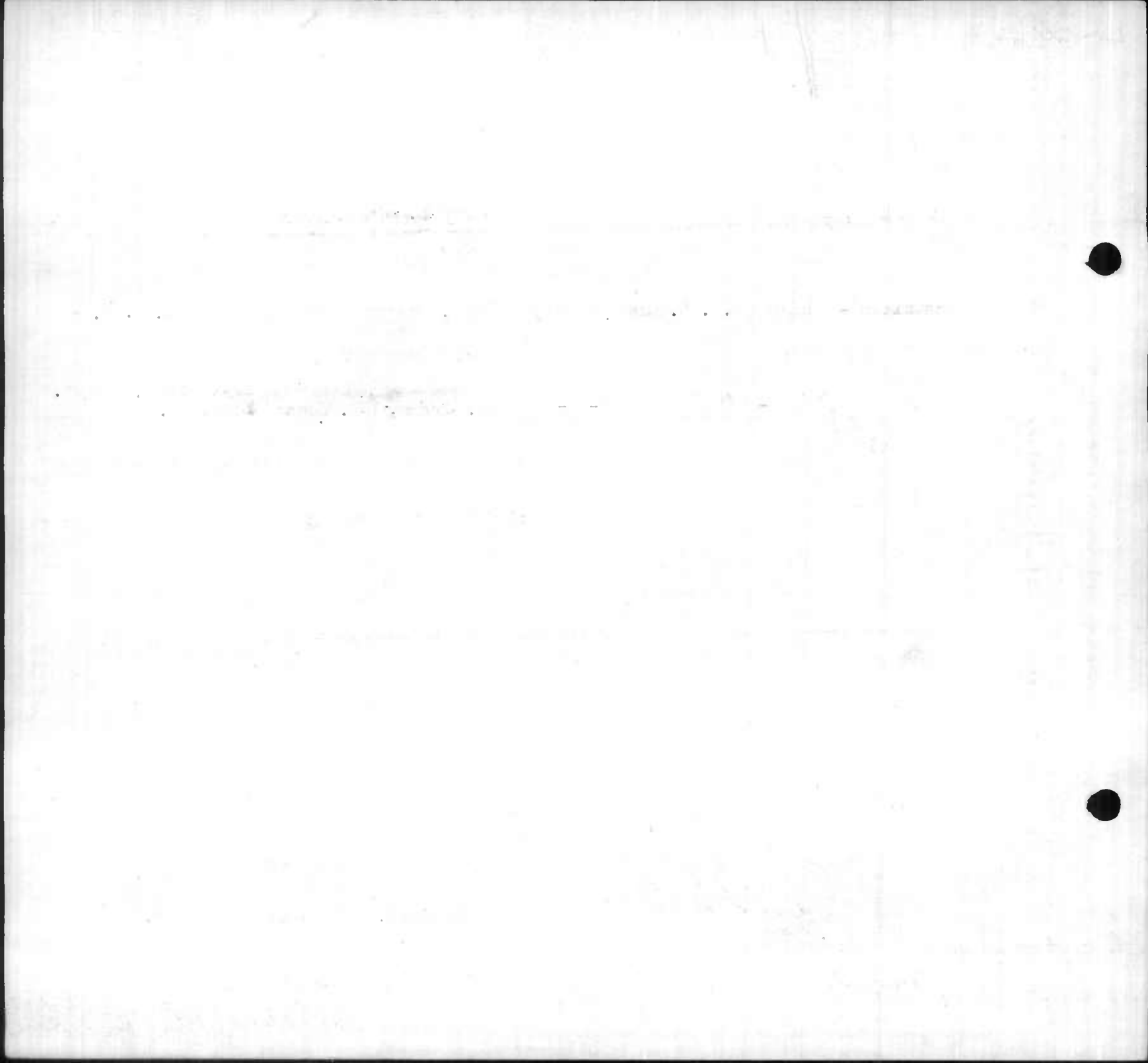
ADDRESS

WATLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

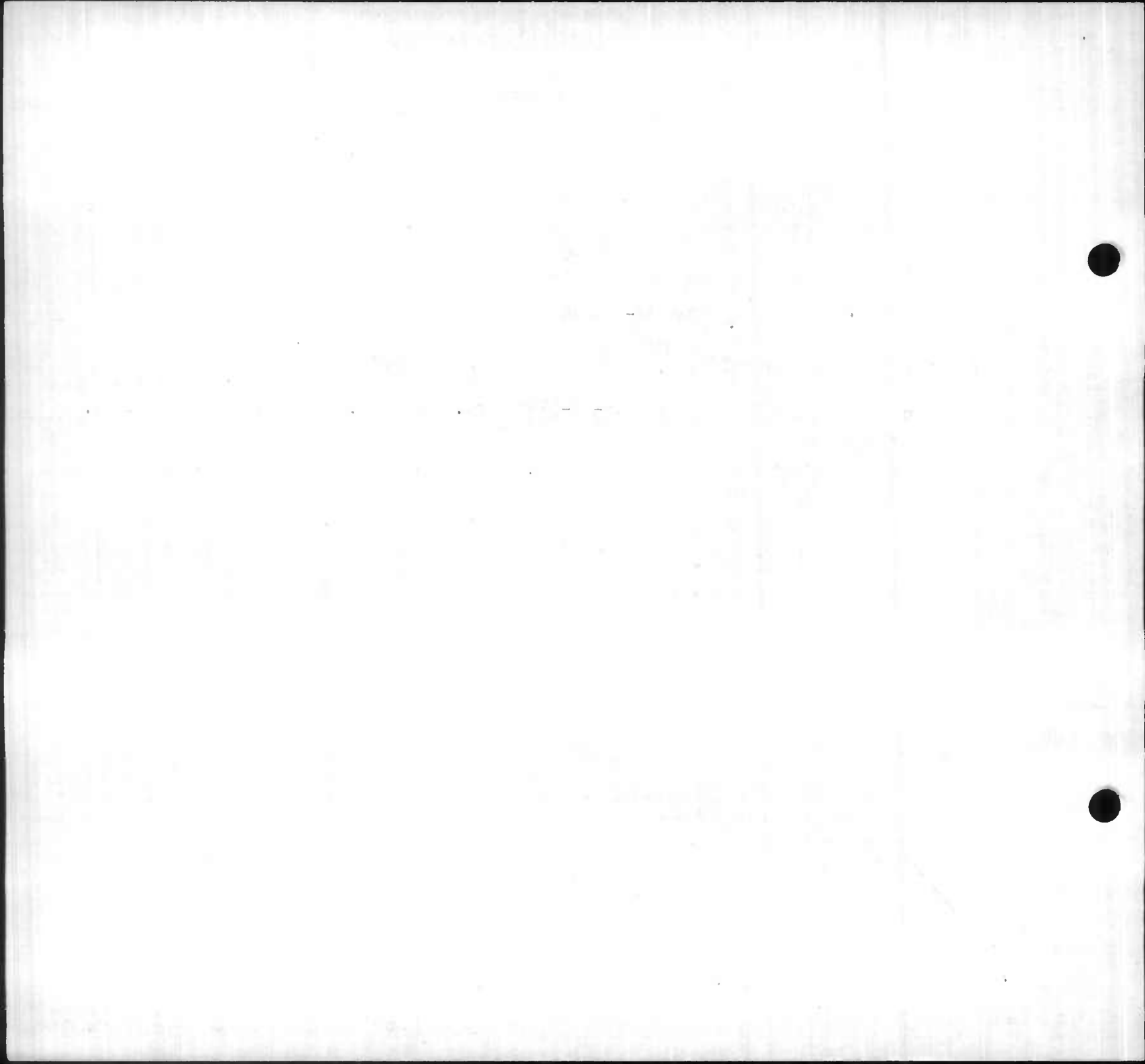
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---|---|---|--|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1134 | | | | |
| BIRTH NO. 65 1134 | | | | | 2. DATE AND HOUR OF DEATH 1/28/65 2:50 AM M. | | | | |
| M.E. CASE NO. 65 1134 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) LOHSS, GEORGE WILLIAM | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY YORK | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) YORK | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 523 North Pershing | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9/12/1900 | 9. AGE (in years last birthday) 64 | 11. BIRTHPLACE (State or foreign country) York, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installer - Awning Co. H. L. Blum Company | | | 10B. KIND OF BUSINESS OR INDUSTRY York, Pennsylvania | | 11. BIRTHPLACE (State or foreign country) York, Pennsylvania | | | | |
| 13. FATHER'S NAME Charles Lohss | | | 14. MOTHER'S MAIDEN NAME Mary Duckworth | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/2/18 - 7/15/19 | | | 16. SOCIAL SECURITY NO. 188-05-6068 | | 17. INFORMANT ADDRESS Mr. Lawrence H. Lohss 1431 South Duke St. York, Pa. | | | | |
| 18. 421.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Congestive Heart Failure | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 or 3 days | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Calcific Aorta Stenosis | | | | | Several Years | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Bronchitis & Emphysema | | | | | Several Years | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 21st 19 64 to January 28th 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 28th 19 65 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE David N. Marine | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/29/65 | | |
| 23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE | | | | | 23D. ADDRESS VA Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | | 24B. DATE 1/29/1965 | | 24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State) York, Pa. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. J. Dickner & Sons North & Pa. Avenue Baltimore, Md. 17 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. | |
|--|--------------|---|-----------------------------|--|---------------------------------|--|--|
| 65 1135 | | | | | | 65 1135 | |
| B-6361 CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | BARDROFF Joseph Edward | | 1/29/65 4:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sina. Hospital of Baltimore | | | | A. STATE MD. B. COUNTY 15-13 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 4250 Pimlico Rd. 15 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 8/1/191 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Braeger-Gutman | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Edward Bardroff | | | | 14. MOTHER'S MAIDEN NAME Mary Durkin | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-18-5950 | | 17. INFORMANT Mrs. Bertha M. Bardroff | | ADDRESS 4250 Pimlico Road Baltimore, Md. 15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 600.01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Renal insufficiency DUE TO (B) Chronic Renal Failure DUE TO (C) Chronic Pyelonephritis 20 years | | INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years 20 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe ASCVD, peripheral gangrene, gout, 20 years | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/19 1965 to 1/29 1965, that (I) (we) last saw the deceased alive on 1/29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lee E. Gresser | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) Lee E. Gresser | | | | 23D. ADDRESS M.D. Sina. Hospital of Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/1965 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkner M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Farkner & Son North & Pa. Avenue Baltimore, Md. | | | |

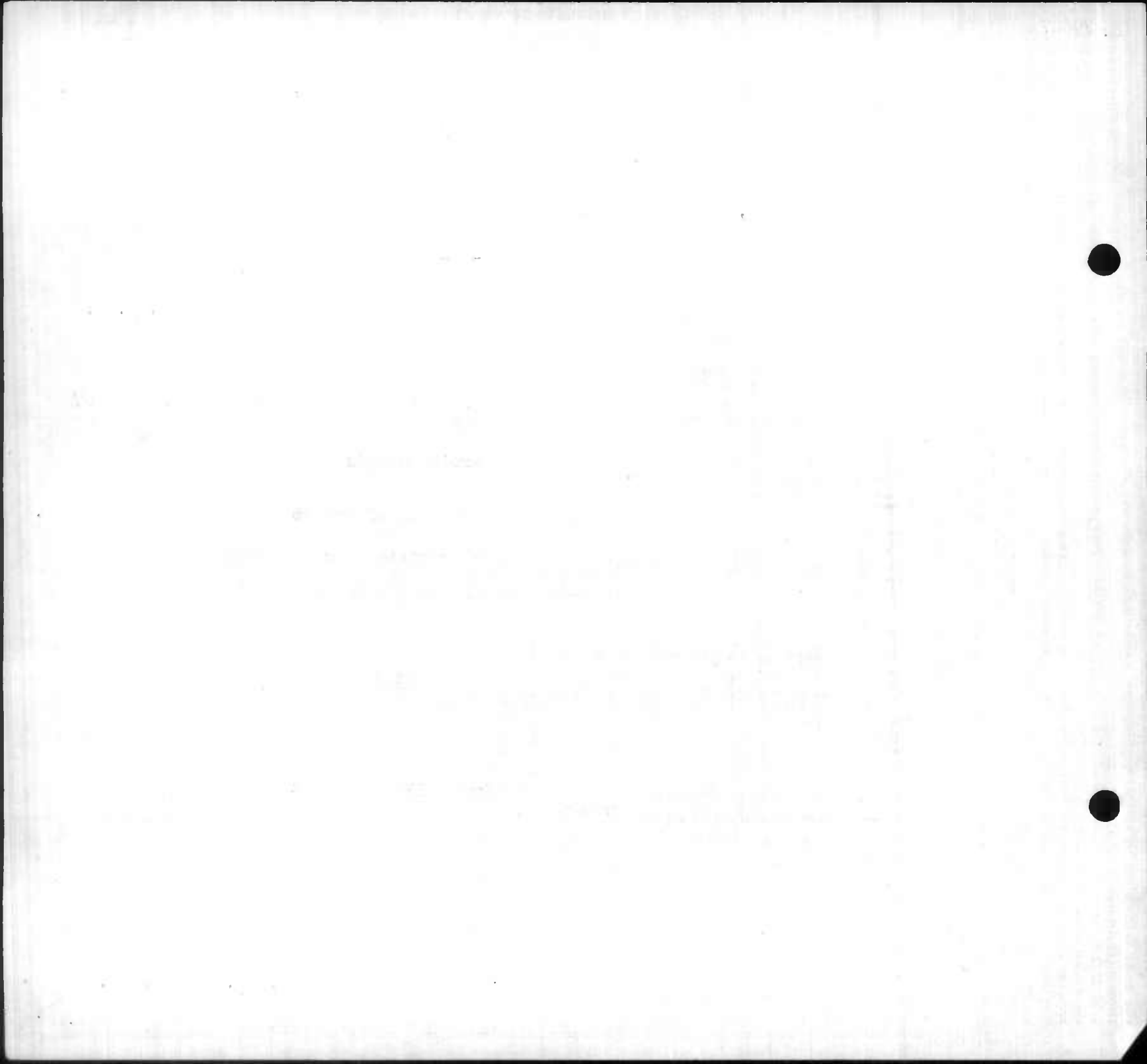


IS: 79887

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

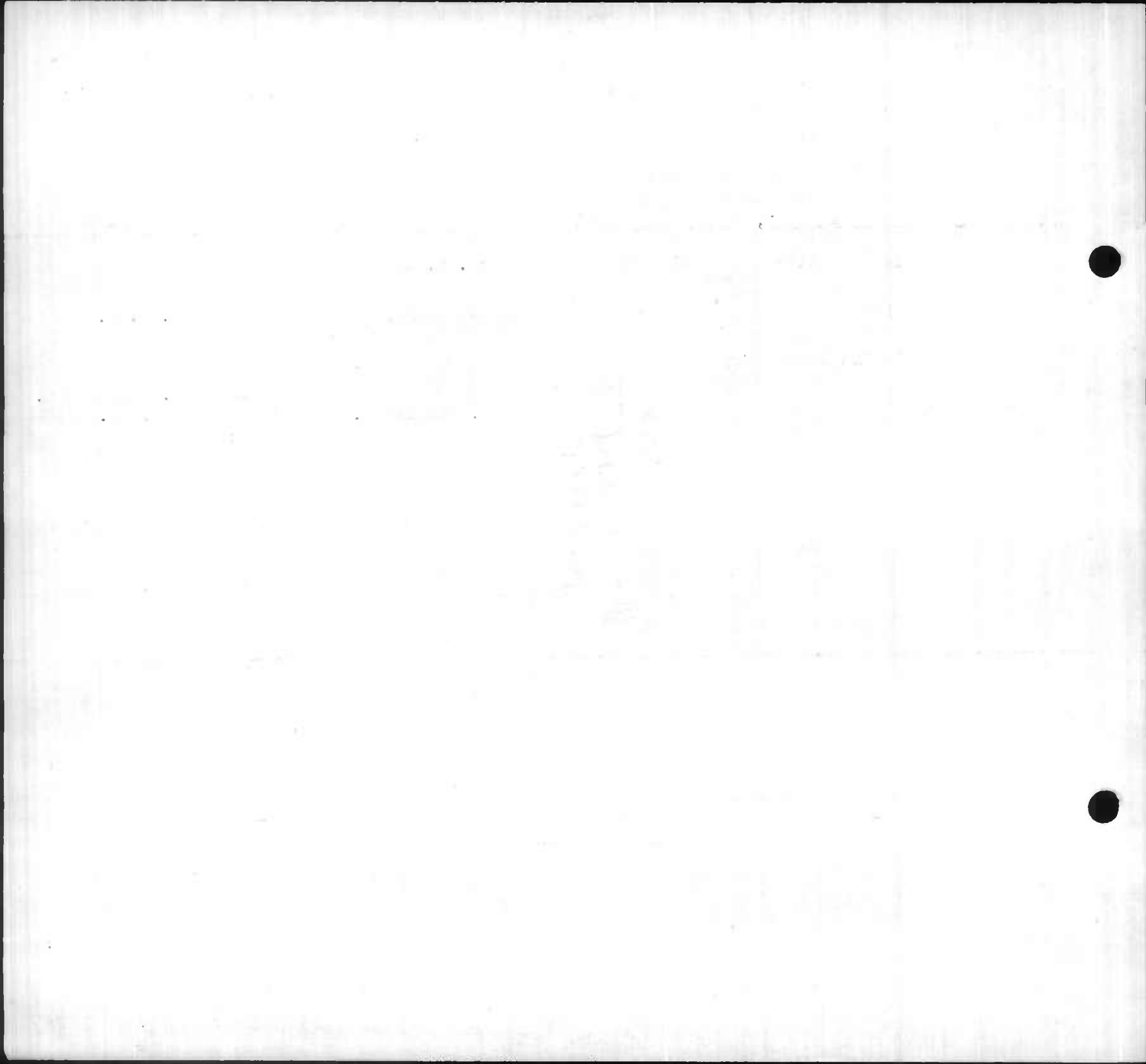
| | | | | | |
|--|---------|--|------------------|--|---|
| BIRTH NO. 65 1136 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1136 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Helen McCraw | | January 23, 1965 | | 8:00 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland | | 26-12 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 4940 Eastern Avenue #21224 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. |
| Female | White | Widowed | 8-31-74 | 90 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U. S. A. | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | RECORDS: BCH: 4940 Eastern Avenue #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Carcinomatosis | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Carcinoma of Breast | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Arteriosclerotic Heart Disease | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 17, 19 43 to January 23, 19 65, that (I) (we) last saw the deceased alive on January 23, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Julius Krevans M.D. | | January 23, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Julius Krevans | | 4940 Eastern Avenue Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/1/65 | | Sacred Heart Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 1 1965 | | Robert E. Farley, M.D. | | William J. Trickett, Son | |
| | | | | ADDRESS | |
| | | | | N.H. Brown | |



FUNERAL DIRECTOR: IMPORTANT

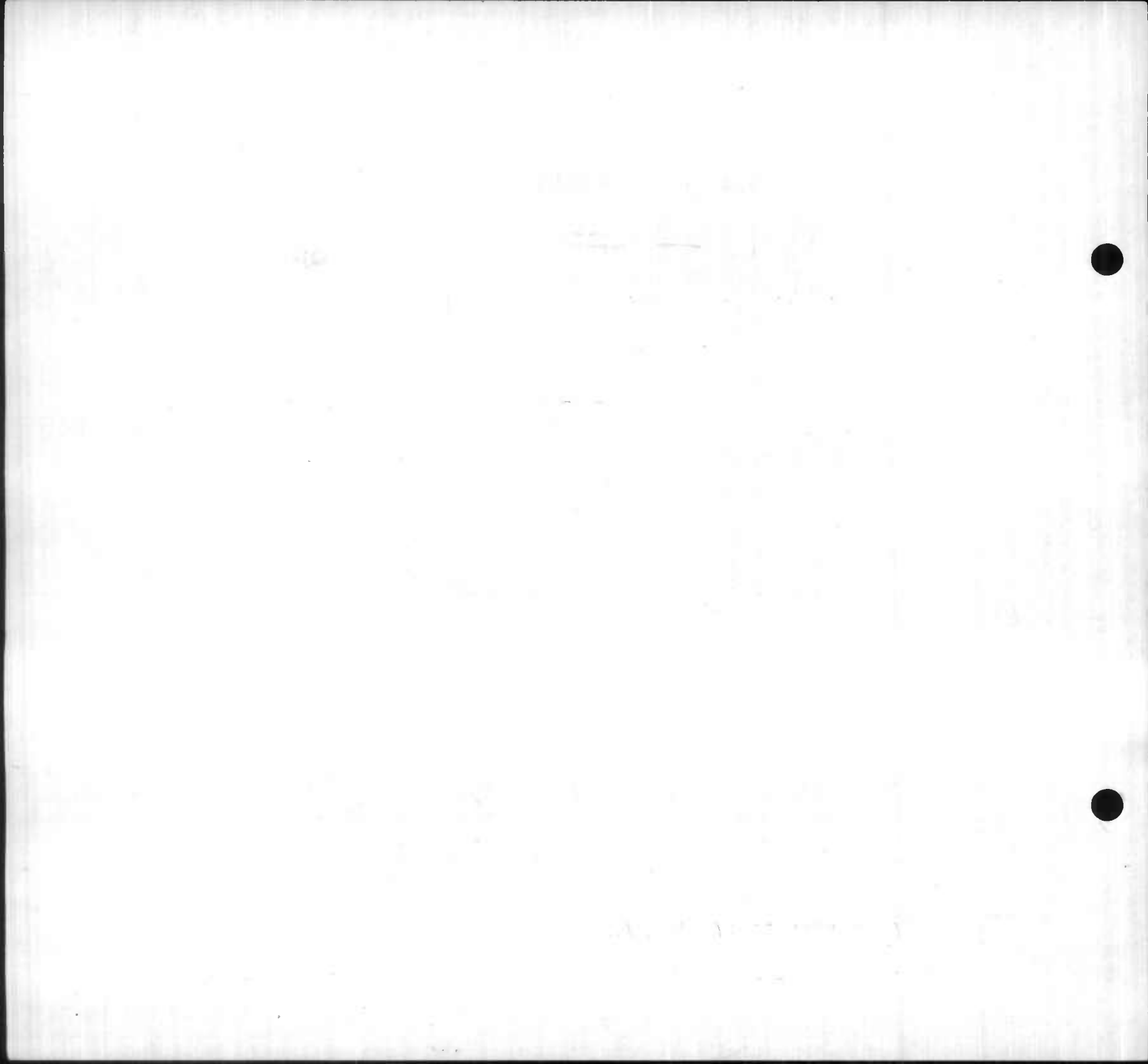
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 65 1137 | | | | 65 1137 | |
|--|--|------------------------|--|---|--|
| BIRTH NO. | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| Elizabeth May Deckert | | | | January 28, 1965 2:20 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| 2095 Rockrose Avenue Ardleigh Nursing Home Baltimore, Maryland 21211 | | | | Maryland 9-03 | |
| 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Female White Widowed | | | | Baltimore | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | D. STREET ADDRESS (If rural, give location) | |
| Housewife | | | | 627 East 37th Street 21218 | |
| 13. FATHER'S NAME | | | | 8. DATE OF BIRTH 9. AGE (In years last birthday) | |
| Christian Eisenhardt | | | | Oct. 6, 1880 84 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 11. BIRTHPLACE (State or foreign country) | |
| No None | | | | Baltimore, Maryland | |
| 16. SOCIAL SECURITY NO. | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| None | | | | U. S. A. | |
| 17. INFORMANT | | | | 14. MOTHER'S MAIDEN NAME | |
| Mr. William K. Deckert | | | | ? | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | ADDRESS | |
| Acute myocardial infarction | | | | 1814 So. Charles St. Baltimore Md. 30 | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Arteriosclerotic cardiovascular disease | | | | 20 min. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | 10 yrs. | |
| Fracture of hip (left) | | | | | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 627 E. 37th Street | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21F. HOW DID INJURY OCCUR? | |
| 1/12/65 10:00A.M. | | | | Fell in living room | |
| 22. I certify that (I) (this hospital) attended the deceased from August 7, 1964 to January 28, 1965, that (I) (we) last saw the deceased alive on January 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Lloyd E. Saylor | | | | Jan. 28, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Lloyd E. Saylor | | | | 3902 Greenmount Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/1/1965 | | Loudon Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 1 1965 | | Robert E. Farkner | | Wm. J. Schuler + Son Baltimore, Md. 21217 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1138 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1138 | |
|---|---------------------|--|---|--|--|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) MR. LIBERATO TROTTA | | | 1-30-65 8:18 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | A. STATE MD. B. COUNTY 27-38 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 1543 SHEFFIELD RD | | |
| 5. SEX M | 6. RACE W | 7. MARRIED UNMARRIED (Type or Print) | 8. DATE OF BIRTH 8-21-83 | 9. AGE (in years last birthday) 81 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pennsylvania Rail Road | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) ITALY | |
| 13. FATHER'S NAME ? Luigi Trotta | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213-10-6342 | | 17. INFORMANT WIFE MRS. ESSIE TROTTA ADDRESS SAME. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | | CAUSE OF DEATH (A) CONGESTIVE Heart Failure DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 12 Hours |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) myocardial Infarction DUE TO | | 12 Hours |
| | | | (C) | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 30 1965 to JANUARY 30 1965 , that (I) (we) lost saw the deceased alive on JANUARY 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David Merritt Mac Millan M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) DAVID MERRITT MAC MILLAN M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-1965 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave. | |



1
L-320

65 1139

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1139

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL LOTZ

2. DATE AND HOUR PRONOUNCED DEAD

1/28/65 1:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

615 N. Collington Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Feb. 8, 1880

9. AGE (In years
Month and day)

84

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Bookster

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Michael Lotz

14. MOTHER'S MAIDEN NAME

Susanna Schwarzkopf

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-26-2782

17. INFORMANT

ADDRESS

Mrs. Catherine Firnstein 615 N. Collington Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/29/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-1-1965

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

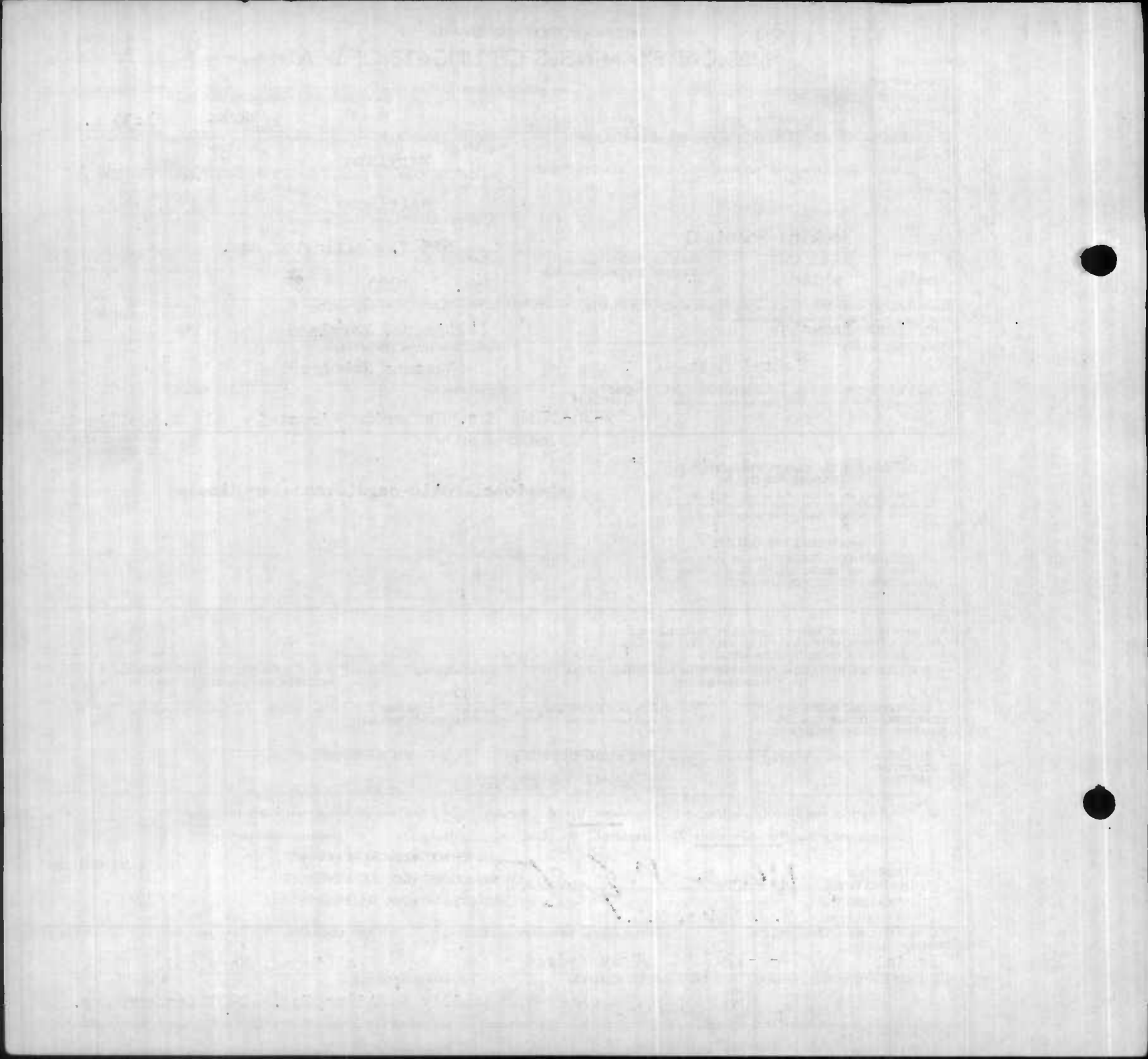
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901 Eastern Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1140 | |
|--|---------------------|---|------------------------------------|---|---|
| BIRTH NO. 65 1140 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Robert Marshall</i> | | 2. DATE AND HOUR OF DEATH <i>1-30-65 1:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>8-01</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital - Balto</i> | | D. STREET ADDRESS (If rural, give location) <i>3176 Ravenwood Ave 13</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>1-24-14</i> | 9. AGE (In years last birthday) <i>51</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Chauffeur</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Franklin L. Marshall</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Krebs</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>212-01-3868</i> | | 17. INFORMANT <i>Mrs. Marie G. Marshall</i> ADDRESS <i>same</i> | |
| 18. <i>153.1 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | AWAITING AUTOPSY REPORT | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>Chronic Septic Shock</i> | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>David Nichols</i> M.D. | | | | 23B. DATE SIGNED <i>1-30-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>David Nichols</i> | | | | 23D. ADDRESS <i>Mercy Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/3/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Gardens of Faith</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Faley, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc 5305 Harford Road</i> | |

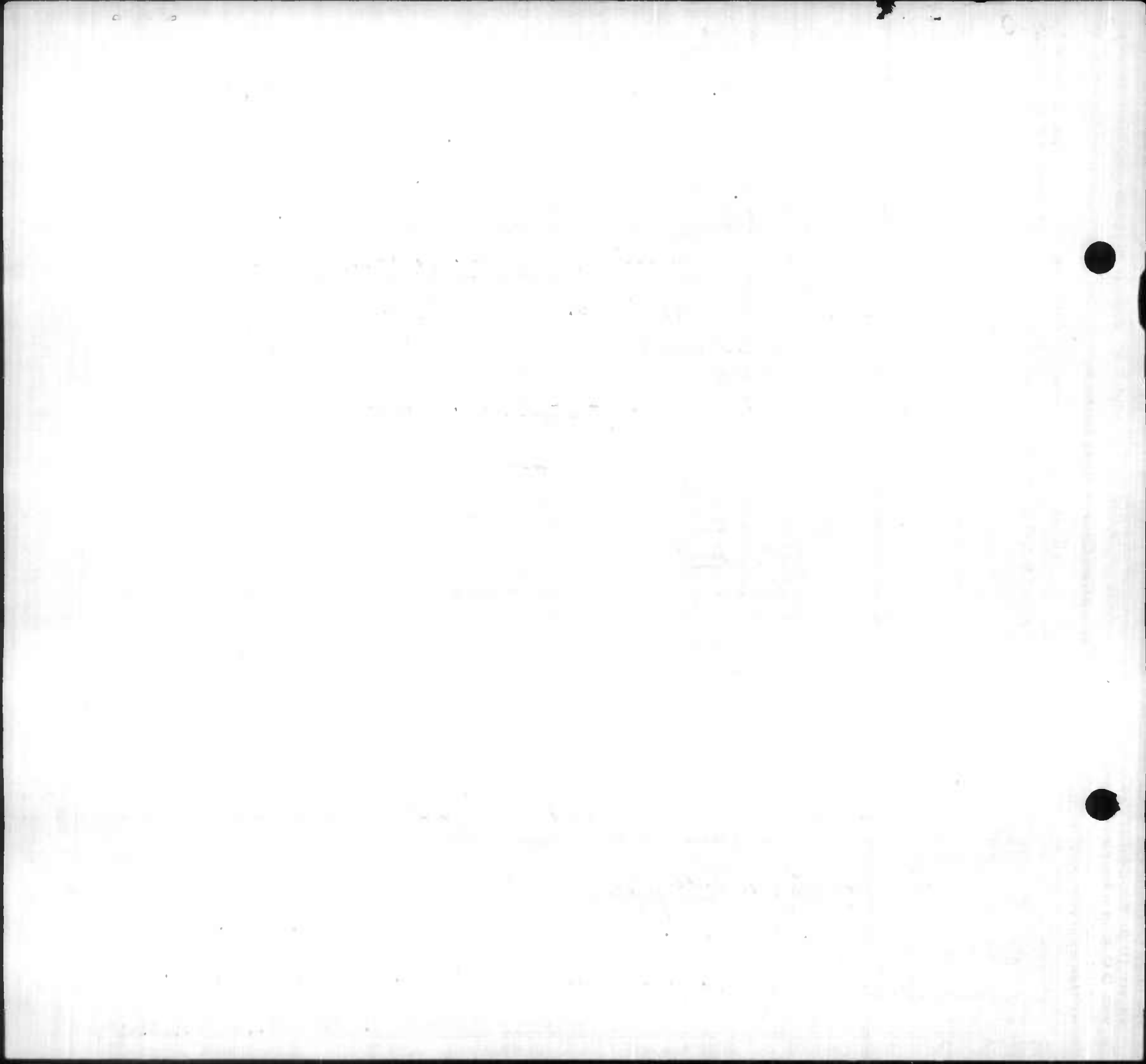
6/28/65 - Infiltrating adenocarcinoma
splenic flexure of colon:
see letter from Mercy Hospital

Filed Bureau of Statistics - American Bldg

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct, or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 65 1141 | | CERTIFICATE OF DEATH | | 65 1141 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ROBERT E. JONES | | JANUARY 30, 1965 7:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE MD. B. COUNTY | | |
| 4612 MAINFIELD AVE. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | |
| | | | D. STREET ADDRESS (If rural, give location) 4612 MAINFIELD AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Mar. 5, 1899 | 9. AGE (In years last birthday) 65 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired |
| 10B. KIND OF BUSINESS OR INDUSTRY Sun Oil Co. | | | 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Robert Jones | | | 14. MOTHER'S MAIDEN NAME Lidia Reeves | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 163-05-9559 | | 17. INFORMANT Mrs. Marjory Jones | |
| | | | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA, INTESTINAL WALL ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO Adenocarcinoma, intestinal wall (B) DUE TO Necrotasis (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION Oct 1963 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Above | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 1957 to 1/30 1965, that (I) (we) last saw the deceased alive on 1/29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas L. Worsley, Jr. | | | | 23B. DATE SIGNED 1/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Thomas L. Worsley, Jr. | | 2900 Alameda Blvd. Balto., Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/2/65 | 24C. NAME OF CEMETERY or CREMATORY Arlington National Cem. | | 24D. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1142 | |
|---|---|--|---|---|--|--|--|
| BIRTH NO. 65 1142 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CARRIE MC CURLEY | | 2. DATE AND HOUR OF DEATH 1-29-65 11:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #29 D. STREET ADDRESS (If rural, give location) 207 ROCK GLEN ROAD. | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10-19-78 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? Mc Coy | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Mr. Raymond A. Barnes | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 422.1 | | | | CAUSE OF DEATH CARDIOCIRCULATORY COLLAPSE | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | |
| | | | | (B) DUE TO PROBABLE PNEUMONIA | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-24 19 65 to 1-29 19 65 , that (I) (we) last saw the deceased alive on 1-29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Oscar Fernandez | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI | | | | 23D. ADDRESS Lutheran Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/2/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. | | ADDRESS 14 Md. | |

LUTHERIAN

10-11-78 KC

F White Wounded

CARDIORESPIRATORY COURSE
ATRIOSCLEROTIC CARDIOMYOPATHY
NIGHT
PROMOTED PUEBLO

1-24 1-24 1-24 1-24

OSCAR E. FERNANDINI
Lecturer
X
1-24

1
G. 4/16

65 1143

BALTIMORE CITY HEALTH DEPARTMENT

65 1143

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN RICHARD GILBERT

2. DATE AND HOUR PRONOUNCED DEAD

1-31-65

11:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3014 Oakcrest Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3014 Oakcrest Avenue 21234

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

Nov 5, 1887

9. AGE (In years last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Monroe Gilbert

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-07-1100

17. INFORMANT

Mrs. Ida E. Gilbert

ADDRESS

same

18. E977X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Exsanguination
DUE TO

(B) Self-inflicted wound of throat
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3014 Oakcrest Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

1 31 App. 10:30 AM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Cut throat with straight razor

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-1-65

EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

2/4/65

23C. NAME OF CEMETERY or CREMATORY

Moreland Mem Park

23D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

N 774,2 FEB 1 1965

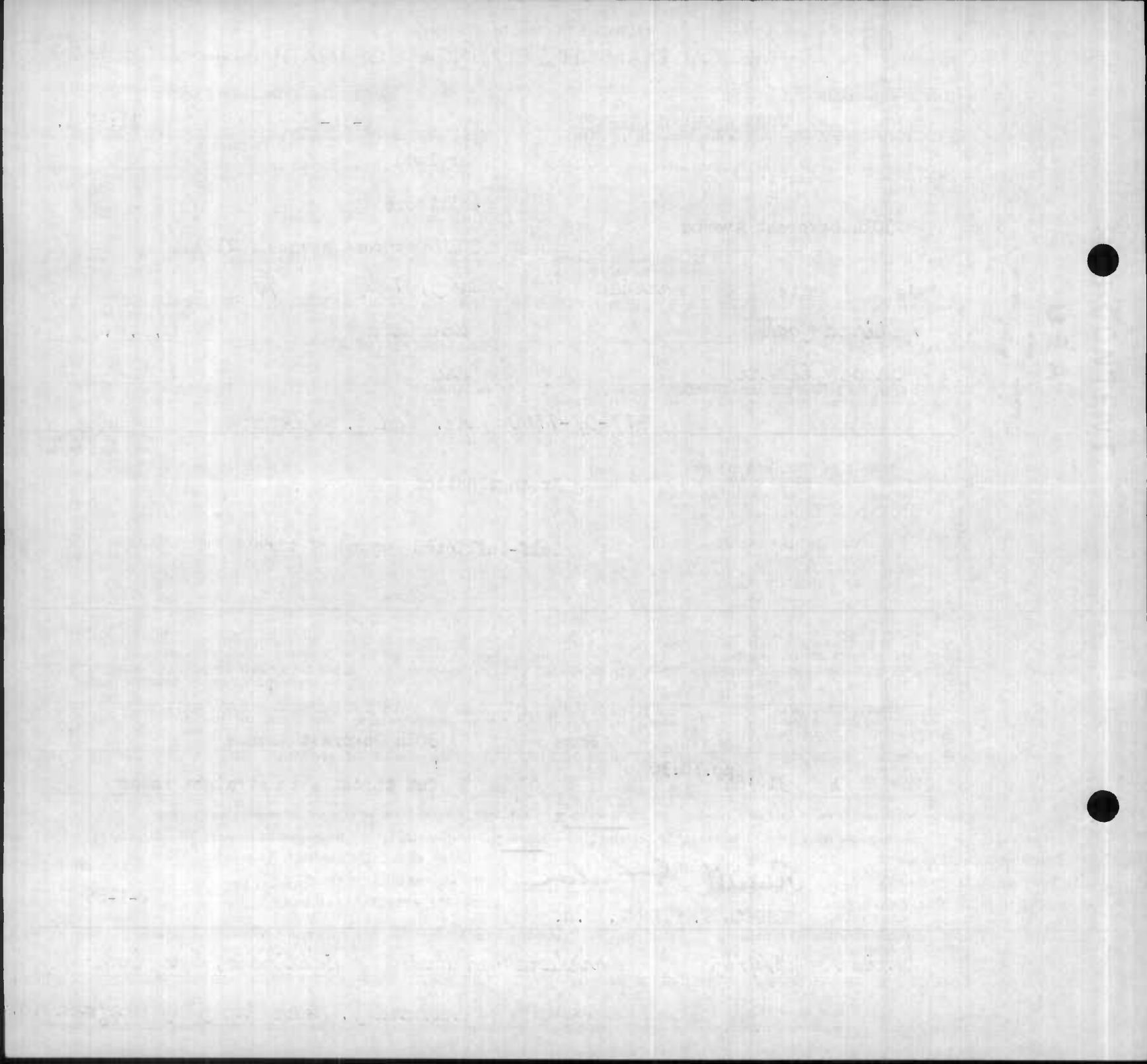
24B. NAME OF REGISTRAR

Robert E. Farber M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Rd.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

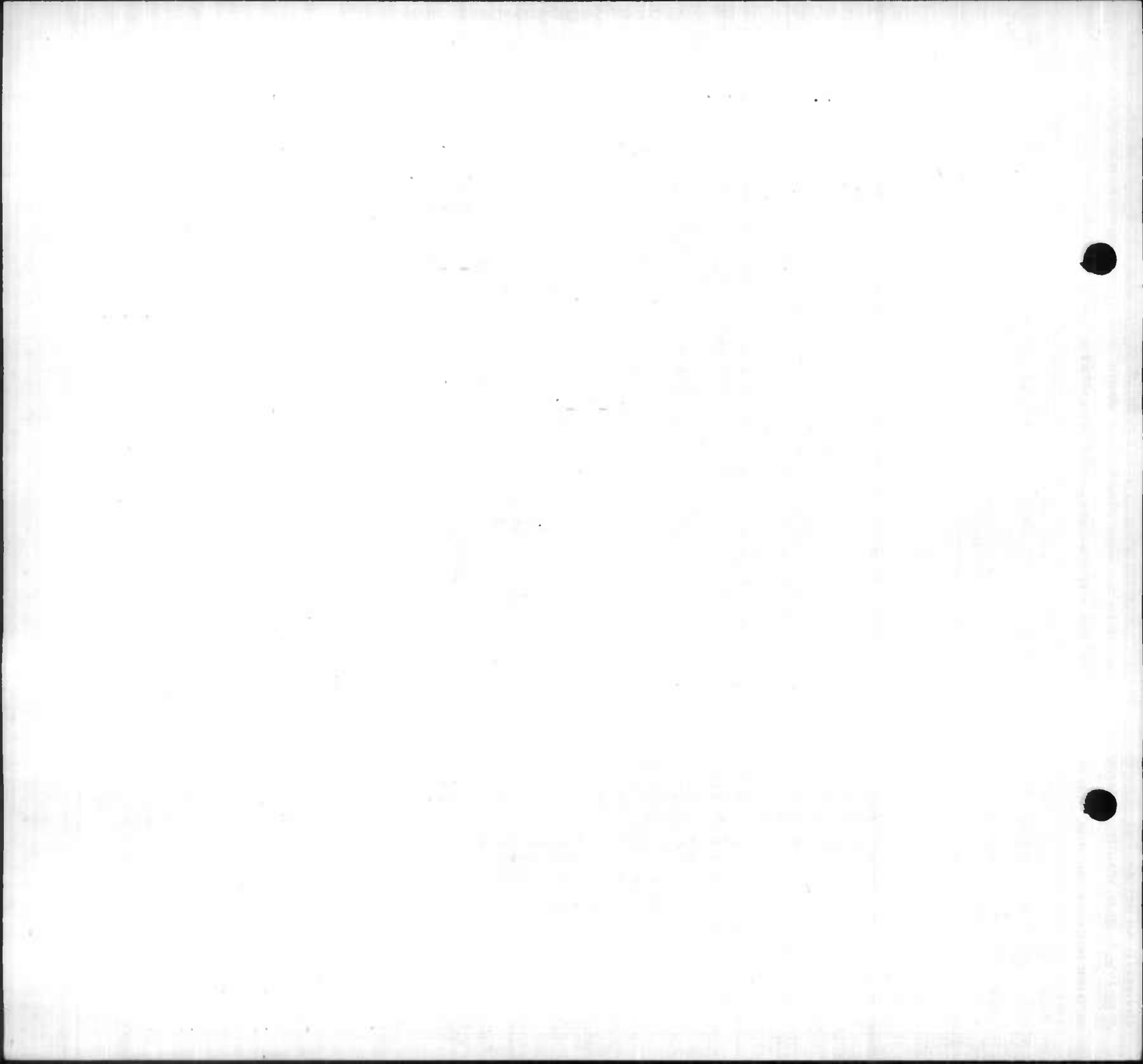
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|--|---|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1144</u> | | | | |
| BIRTH NO. <u>(5) 65 1144</u> | | | | | | | | | |
| M.E. CASE NO. <u>65 1144</u> | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Michael P. Noppenberger</u> | | | | | 2. DATE AND HOUR OF DEATH <u>Jan. 30/65</u> <u>7:08</u> <u>A</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>8-05</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>1403 Calflview Ave</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>1403 Calflview Ave</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Oct. 18/75</u> | 9. AGE (In years last birthday) <u>89</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Joseph Noppenberger</u> | | | 14. MOTHER'S MAIDEN NAME <u>Connie</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>218-26-7243</u> | | 17. INFORMANT <u>Mrs. Gertrude Noppenberger</u> | | ADDRESS <u>Same</u> | | |
| 18. <u>157X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) DUE TO <u>Carcinoma of head of pancreas</u> (B) DUE TO <u>Generalized arteriosclerosis</u> (C) <u>10 years</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1957</u> 19 <u>1/30</u> to <u>1/30</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>E. J. Offay Jr.</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <u>2/1/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. J. Offay Jr.</u> | | | | | 23D. ADDRESS <u>2843 St. Paul Street</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/2/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | | |
| 25A. DATE REC'D BY HEALTH/DEPT. <u>FEB 1 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR <u>Wittke F. B. 4101 Edmondson</u> | | | ADDRESS <u>Ave</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1145 | |
|--|-----------------------------|---|---|--|--|
| BIRTH NO. 65 1145 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) A. DORA L. GERKENS | | | | 2. DATE AND HOUR OF DEATH FEBRUARY 1, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2602 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4316 PARKWOOD AVENUE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | |
| | | | | D. STREET ADDRESS (If rural, give location) 4316 PARKWOOD AVENUE | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 12-6-1878 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME HANS LENTFER | | | 14. MOTHER'S MAIDEN NAME JULIE WULF | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 212-16-8371 B | 17. INFORMANT MISS MINNIE GERKENS, ADDRESS SAME | |
| 18. 4200 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. If means the disease, injury or complication which caused death.) coronary heart disease | | | CAUSE OF DEATH (A) coronary heart disease (B) atherosclerosis (C) Pulmonary emphysema | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 1964 to January 26, 1965 , that (I) (we) last saw the deceased alive on January 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Mario E. Comas | | | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) MARIO E. COMAS | | | | 23D. ADDRESS 5101 Belair Rd | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY OAKLAWN CEMETERY | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | 25B. NAME OF REGISTRAR Robert E. Jarboe, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214 |



Z-100

65 1146

BALTIMORE CITY HEALTH DEPARTMENT

65 1146

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD G. ZEPP

2. DATE AND HOUR PRONOUNCED DEAD

1-31-65

11:26 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF DECEASED
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR INSTITUTION ADDRESS OR LOCATION

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cockeysville

D. STREET ADDRESS (If rural, give location)

414 Old Trail Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Dec. 3, 1905

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Restaurant Owner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Zepp

14. MOTHER'S MAIDEN NAME

Virginia Kahl

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-10-3850

17. INFORMANT

ADDRESS

Mrs. Elizabeth E. Zepp

same

18. F976X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Craniocerebral injury
DUE TO Due to gunshot wound of headINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Basement Office

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Basement Office of
Zepp's Restaurant, Cockeysville, Md.21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 27 App. 6:30
1965 AM

21E. INJURY OCCURRED

WHILE AT
WORK ☒NOT WHILE
AT WORK ☐21F. HOW DID INJURY OCCUR?
Shot self in right tem-
ple with .25 cal. automatic

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/3/65

23C. NAME of CEMETERY or CREMATORY

Moreland Mem. Park

23D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Rd.

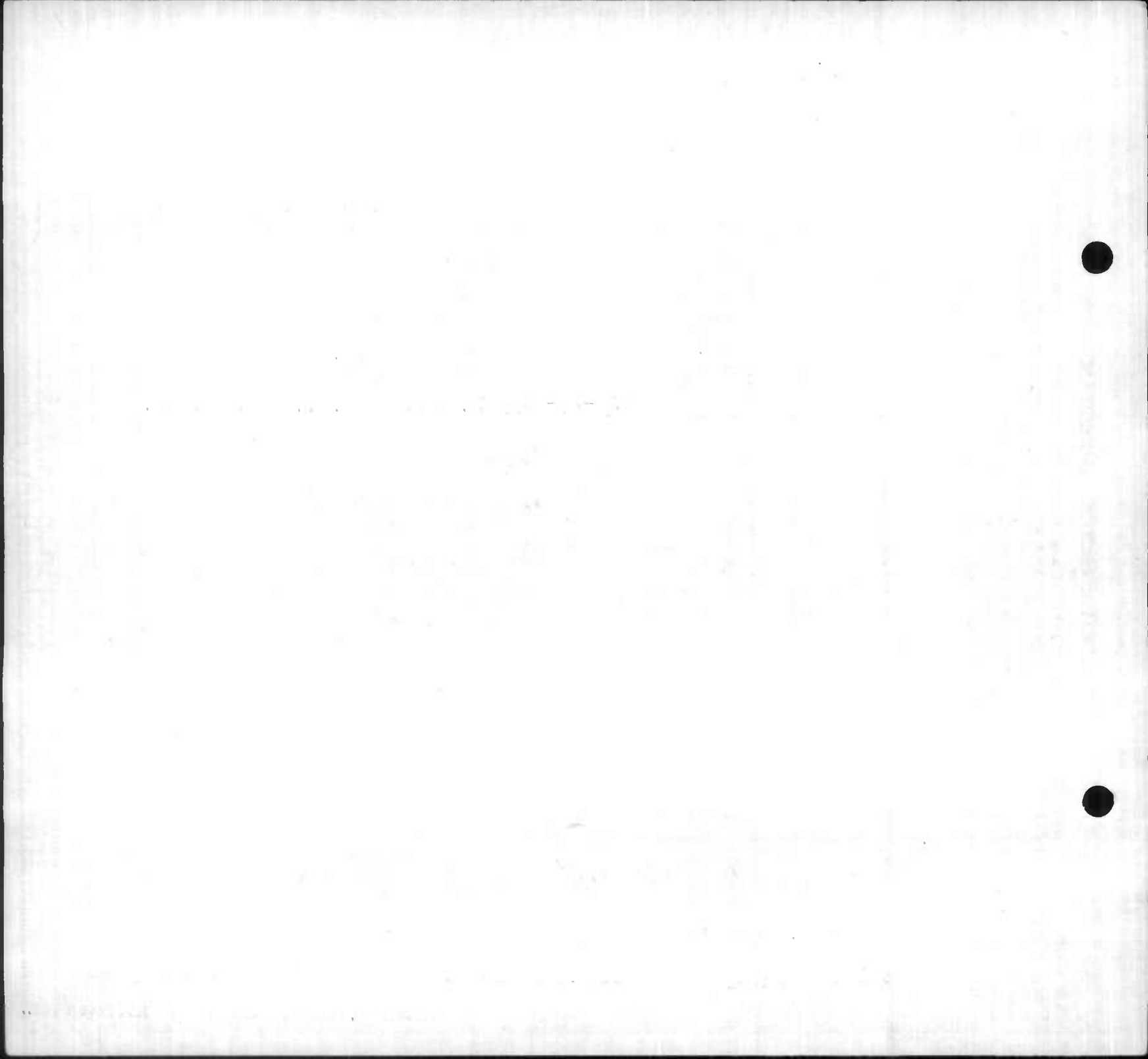
ADDRESS

Letter from M.E.'s office 3-3-65 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1147 | |
|---|------------------|--|------------------------------------|--|---|
| BIRTH NO. 65 1147 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CASSANN, ELLA | | 2. DATE AND HOUR OF DEATH 1/31/65 9:10 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 8-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 3417 Harford Rd 21218 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 5-11-94 | 9. AGE (In years last birthday) 70 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptometer Oper | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME John Wm. Hodgins | | 14. MOTHER'S MAIDEN NAME METTA L. JARVIN | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-14-9455 | | 17. INFORMANT Mr. Thomas T. G. Pearce, Jr. | |
| 18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Irreversible shock ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Failure Prob. myocardial infarct | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Actually related pt had extensive resection of ascending ca of colon | | | | | |
| 19A. DATE OF OPERATION 3 Jan 65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca colon | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/21/65 19 to 1/31/65 19, that (I) (we) last saw the deceased alive on 1/31/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Theodore H. Dodenhoff M.D. | | | | 23B. DATE SIGNED 1/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) Theodore H. Dodenhoff | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/65 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Jarvin | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd. | |

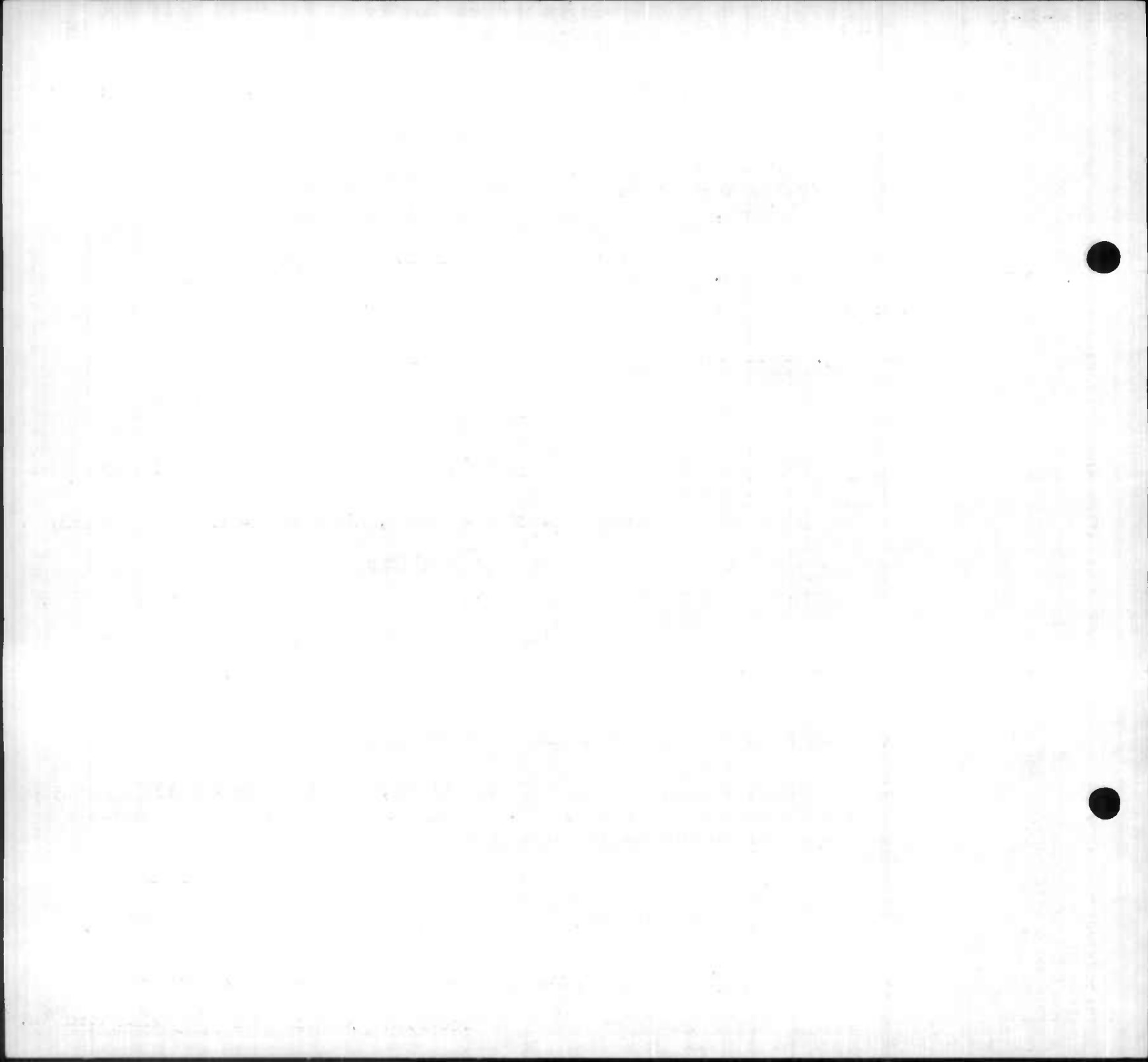


cdg: 30-38-19
D-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

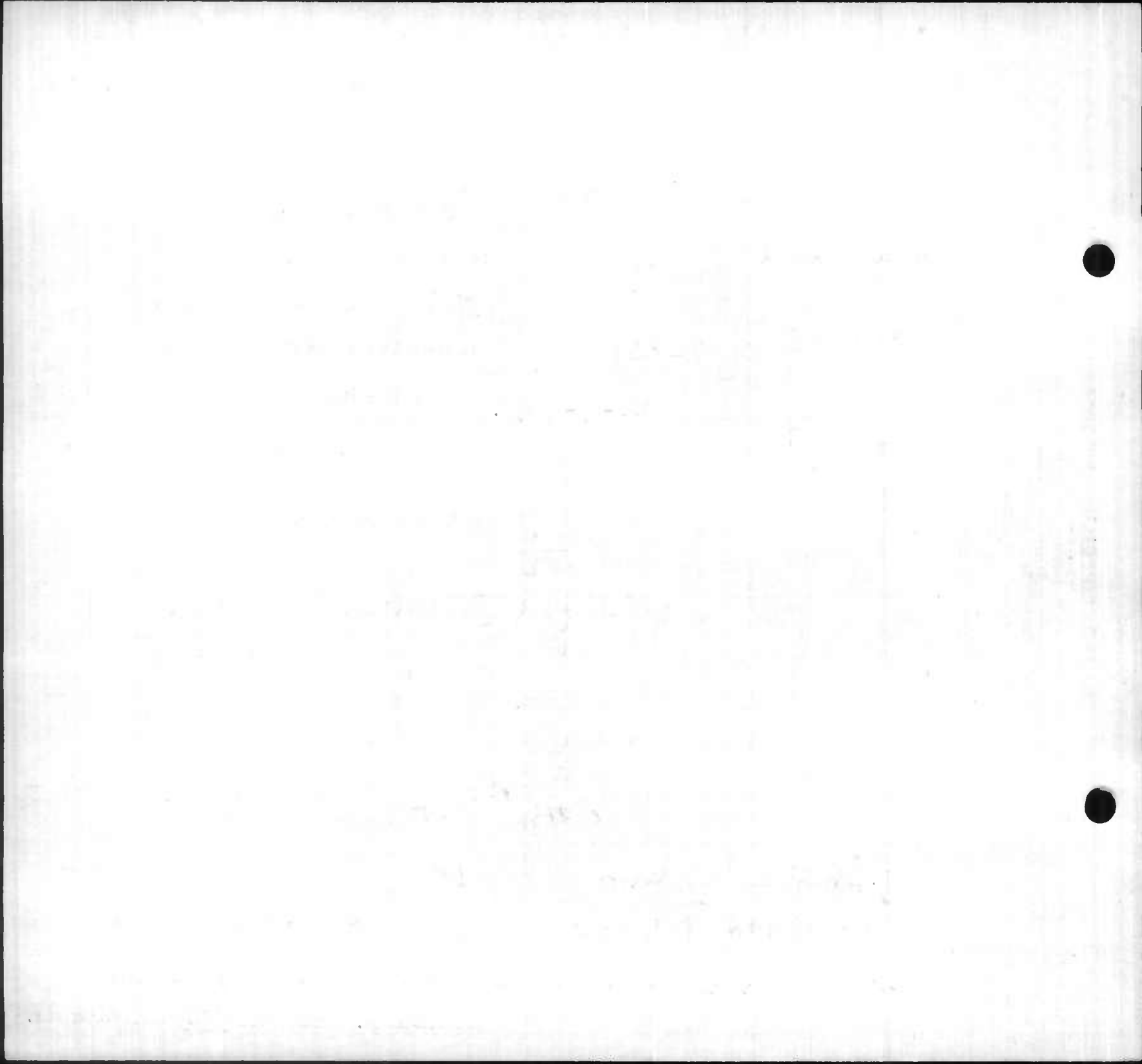
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1148 | |
|---|---------|--|------------------|--|------------------------------|
| BIRTH NO. 65 1148 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | January 30, 1965 4:30 P.M. | | | |
| Elizabeth Dranbauer | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland 2602 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5104 Sipple Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months: Days |
| Female | White | Married | 10-19-1886 | 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| James E. Williams | | May Fowler | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | RECORDS: BCH 4940 Eastern Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) Uremia | | 1 year | |
| ANTECEDENT CAUSES | | (B) Nephrosclerosis, Kimmelstiel-Wilson Nephropathy | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Diabetes Mellitus | | | |
| II | | Congestive Heart Failure | | 3 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 13, 1964 to January 30, 1965, that (I) (we) lost saw the deceased alive on January 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Robert Cooke | | | | 1-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Robert Cooke | | | | 4940 Eastern Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/3/65 | | Oak Lawn Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 1 1965 | | Robert E. Fisher, M.D. | | Leonard J. Ruck Inc 5305 Harford Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

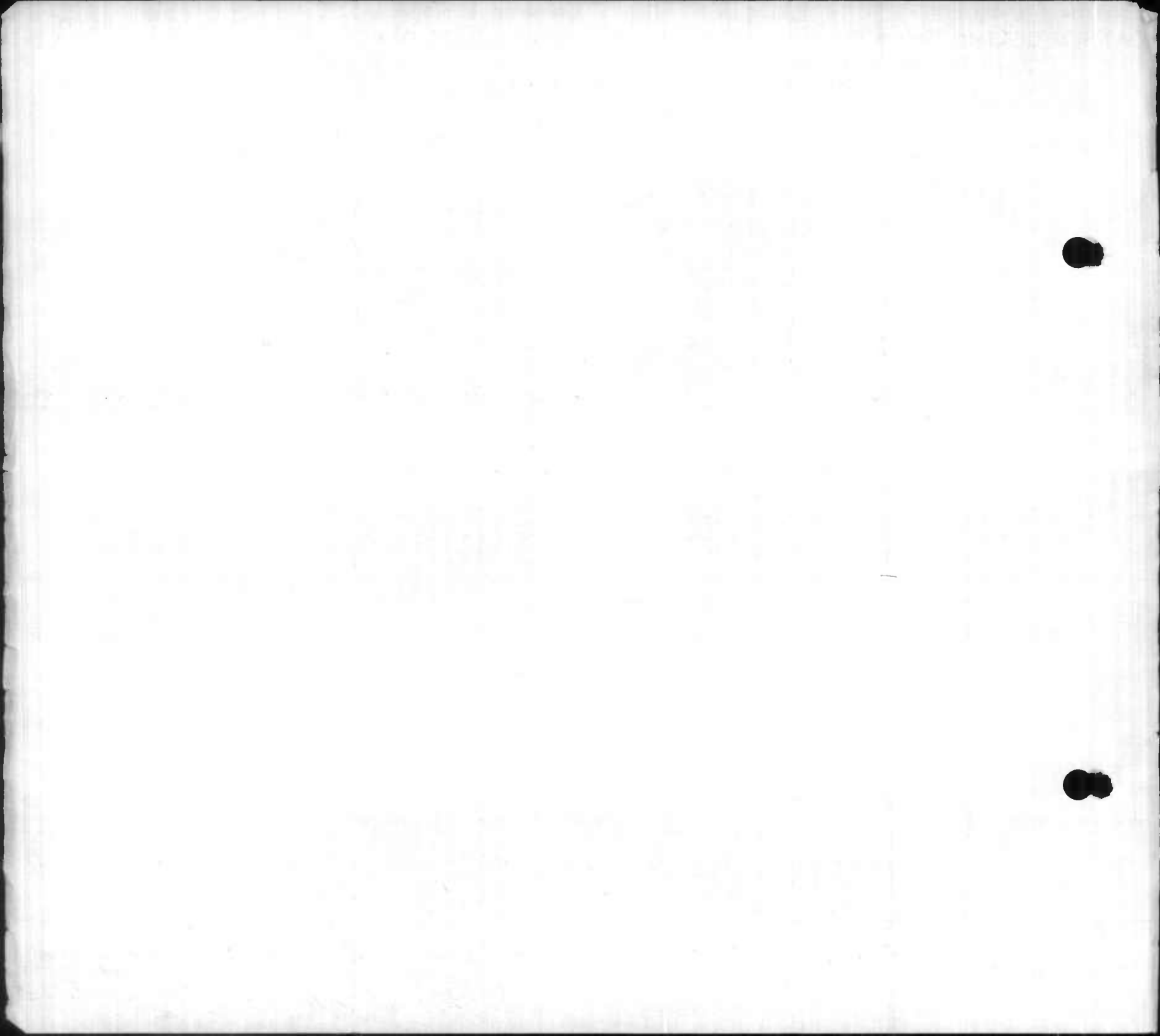
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1149 | |
|--|-------------------------|---|---------------------------------------|--|---|
| BIRTH NO. 65 1149 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ROSARIO DI BLASI | | 2. DATE AND HOUR OF DEATH 11/31-1965 11.05 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3005 Louise Ave | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2705 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3005 Louise Ave | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M. | 8. DATE OF BIRTH 12-16-1887 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Sicily (ITALY) | |
| 12. CITIZEN OF WHAT COUNTRY? American | | 13. FATHER'S NAME JOSEPH DI BLASI | | 14. MOTHER'S MAIDEN NAME MARCELLA RAIMONDI | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-09-3704B | | 17. INFORMANT SISTER 4532 Harford Rd. | |
| 18. 332X+260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Cerebral arteriosclerosis | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus Hypostatic Bronchopneumonia | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-1 19 65 to 1-30 19 65 , that (I) (we) last saw the deceased alive on 1-31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sebastian Russo M.D. | | | | 23B. DATE SIGNED 11/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO M.D. | | | | 23D. ADDRESS 5017 Harford Rd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|-------------------------|--|---|------------------------|---|--|---|--|---|--|--|--|--|
| BIRTH NO. 65-03015 65 1150 | | | | | CERTIFICATE OF DEATH X | | | | | Registered No. 65 1150 | | | | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY RITTER SHOFER | | | | | | | | | | 2. DATE AND HOUR OF DEATH January 27 1965 10:25 p.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #34 5300 D. STREET ADDRESS (If rural, give location) 8428 Oakleigh Rd. | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH Jan. 24 1965 | | 9. AGE (In years last birthday) 4 | | If Under 1 Yr. Months: 4 Days: 4 Hours: 4 Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Edward James Rittershofer | | | | | | 14. MOTHER'S MAIDEN NAME Ema P. Hollen | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT EDW. J. RITTERSHOFER 8428 OAKLEIGH RD. | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory depression shock | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 hours | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Extracranial hemorrhage | | | | | | | | | | Life | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity | | | | | | | | | | Life | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 24, 1965 to Jan. 27, 1965 , that (I) (we) last saw the deceased alive on Jan. 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Victoria S. TAYENCO M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED January 27, 1965 | | | | |
| 23C. PHYSICIAN'S NAME (Type) VICTORIA S. TAYENCO | | | | | | | | 23D. ADDRESS Mary Hospital, Baltimore Md. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 1/28/65 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cem. | | | | 24D. LOCATION (City, town, or county) (State) BALTO. CO., MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | | 25C. FUNERAL DIRECTOR John E. Phelan 8521 Loch Haven Rd. Balto Md 21204 | | | | | | |



M 452

65 1151

BALTIMORE CITY HEALTH DEPARTMENT

65 1151

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

ETHEL PRICE MULLINX

2. DATE AND HOUR PRONOUNCED DEAD

January 28, 1965 1:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE CORRECTED 2-15-65
 FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 2-17-65
 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

107 LaPaix Lane

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 15, 1904

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife Secretary

10B. KIND OF BUSINESS OR INDUSTRY

U. of Md. Ext. Service

11. BIRTHPLACE (State or foreign country)

Towson, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Elijah A. Price

14. MOTHER'S MAIDEN NAME

Florence Chilcoat

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

213-38-2500

17. INFORMANT

Family records

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary Embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Thrombophlebitis of rt. Popliteal and
Femoral Artery, Veins

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Multiple Traumatic Injuries.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

York Rd. and Hillside Avenue

21D. TIME
OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

12 14 '65 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver in auto-auto collision.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
 resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/28/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/30/65

23C. NAME OF CEMETERY or CREMATORY

Forest Baptist Church Cem.

23D. LOCATION

(City, town, or county)

(State)

Upperco, Balto. Co. Maryland

24A. DATE REC'D BY HEALTH DEPT.

N 869 FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John Burns Sons 610-12 York Rd. Towson

ADDRESS

V.S. 153 & Letters from M.E.'s Office

2-15-65

M.H.

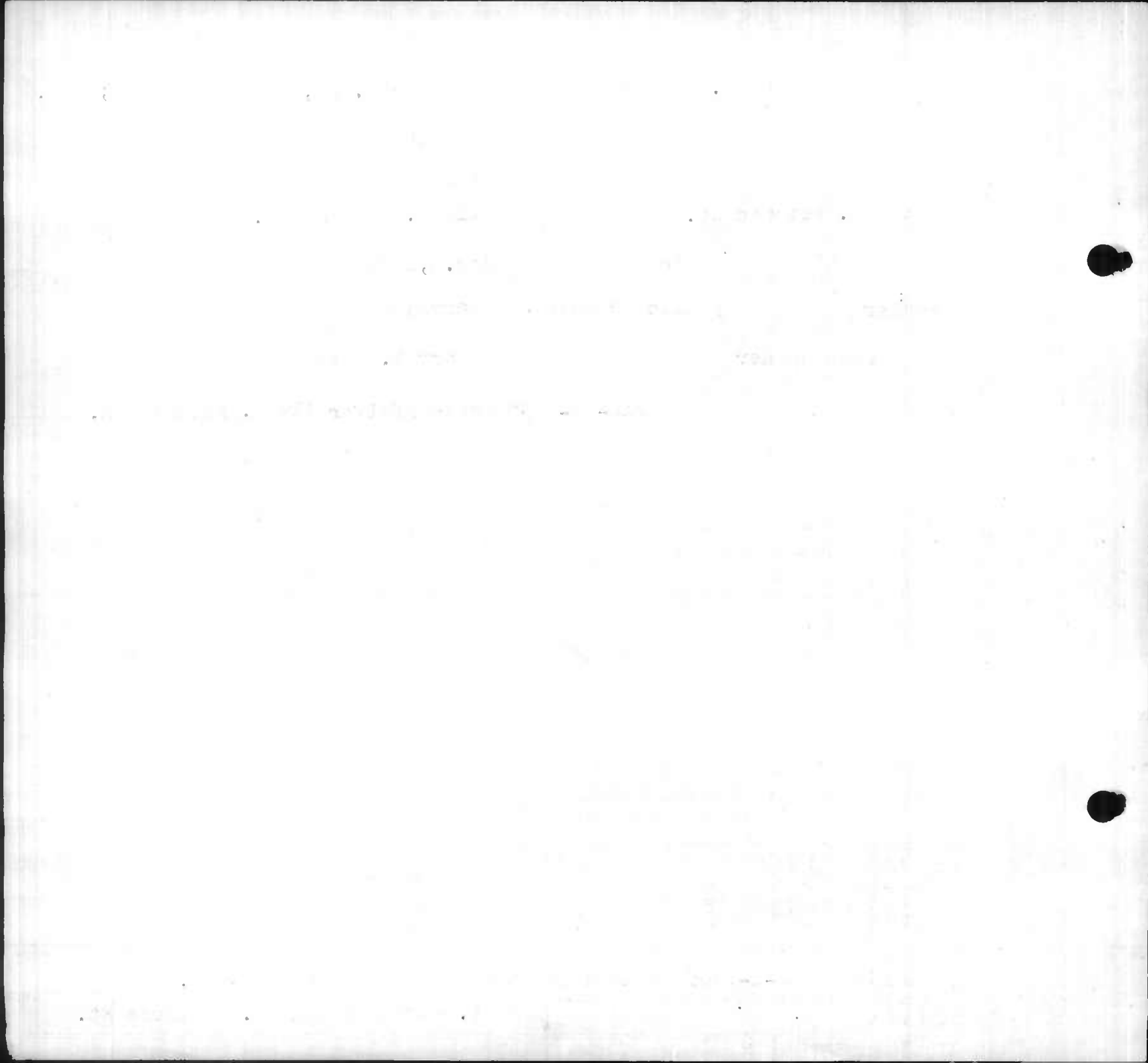
2-17-65

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

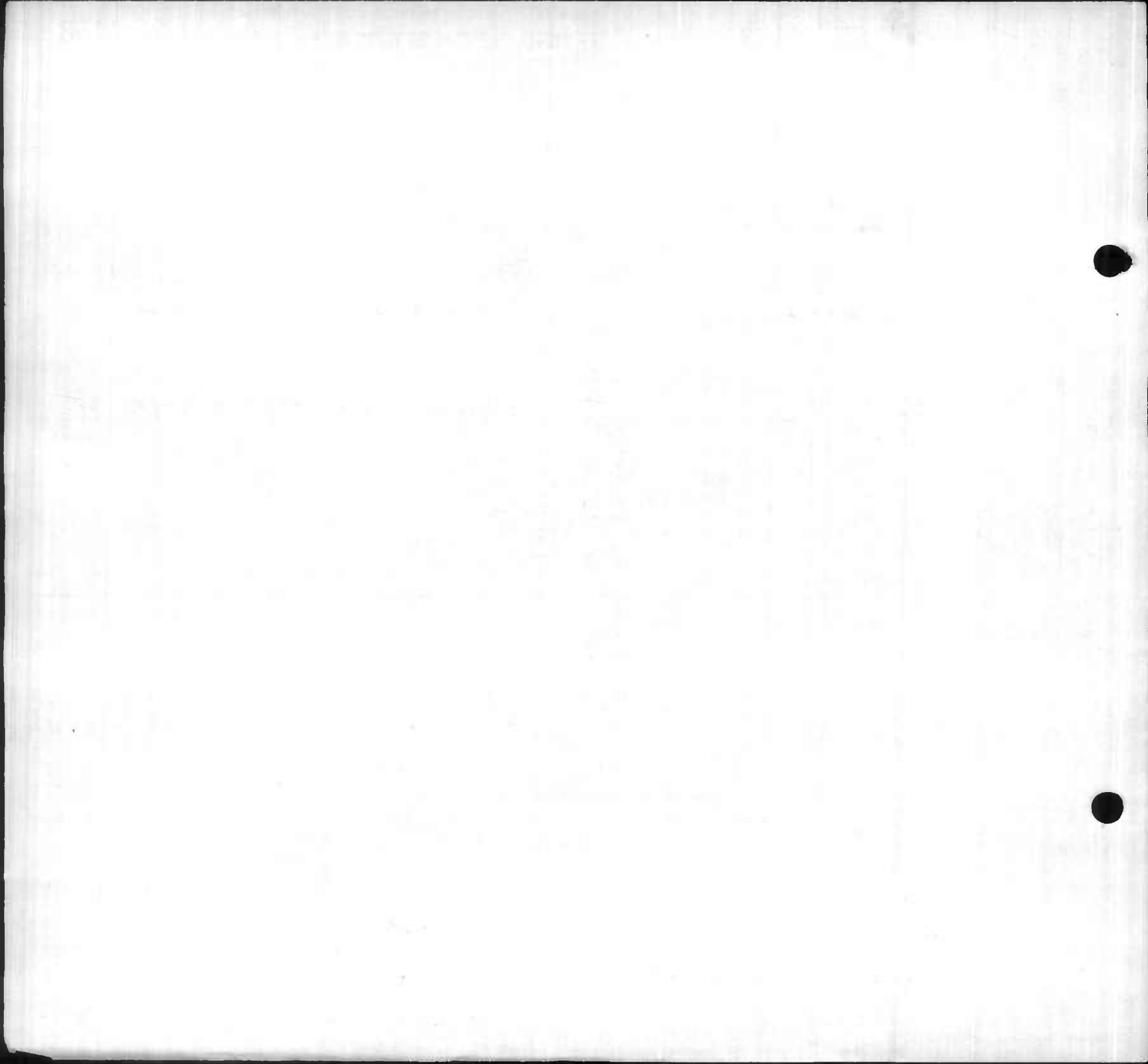
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 65 1152 | | CERTIFICATE OF DEATH | | Registered No. 65 1152 | |
| 1. NAME OF DECEASED (Type or Print) Helen C. Neuner | | | 2. DATE AND HOUR OF DEATH Jan. 28, 1965 5:05 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 119 S. Potomac St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 102 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 119 S. Potomac St. | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Jan. 6, 1905 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | 10B. KIND OF BUSINESS OR INDUSTRY Public Schools | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Neuner | | | 14. MOTHER'S MAIDEN NAME Mary E. Shaw | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-4237 | | 17. INFORMANT ADDRESS Marie Pfeifer 119 S. Potomac St. | |
| 18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH Dissipated Carcinoma (A) DUE TO Carcinoma of Kidney (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 3 months |
| | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1964 to Jan 27 1965 , that (I) (we) last saw the deceased alive on Jan 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles E. MacMurray M.D. | | | 23B. DATE SIGNED Jan 29, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-1965 | | 24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR ADDRESS B. Dabrowski 2818 E. Baltimore St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

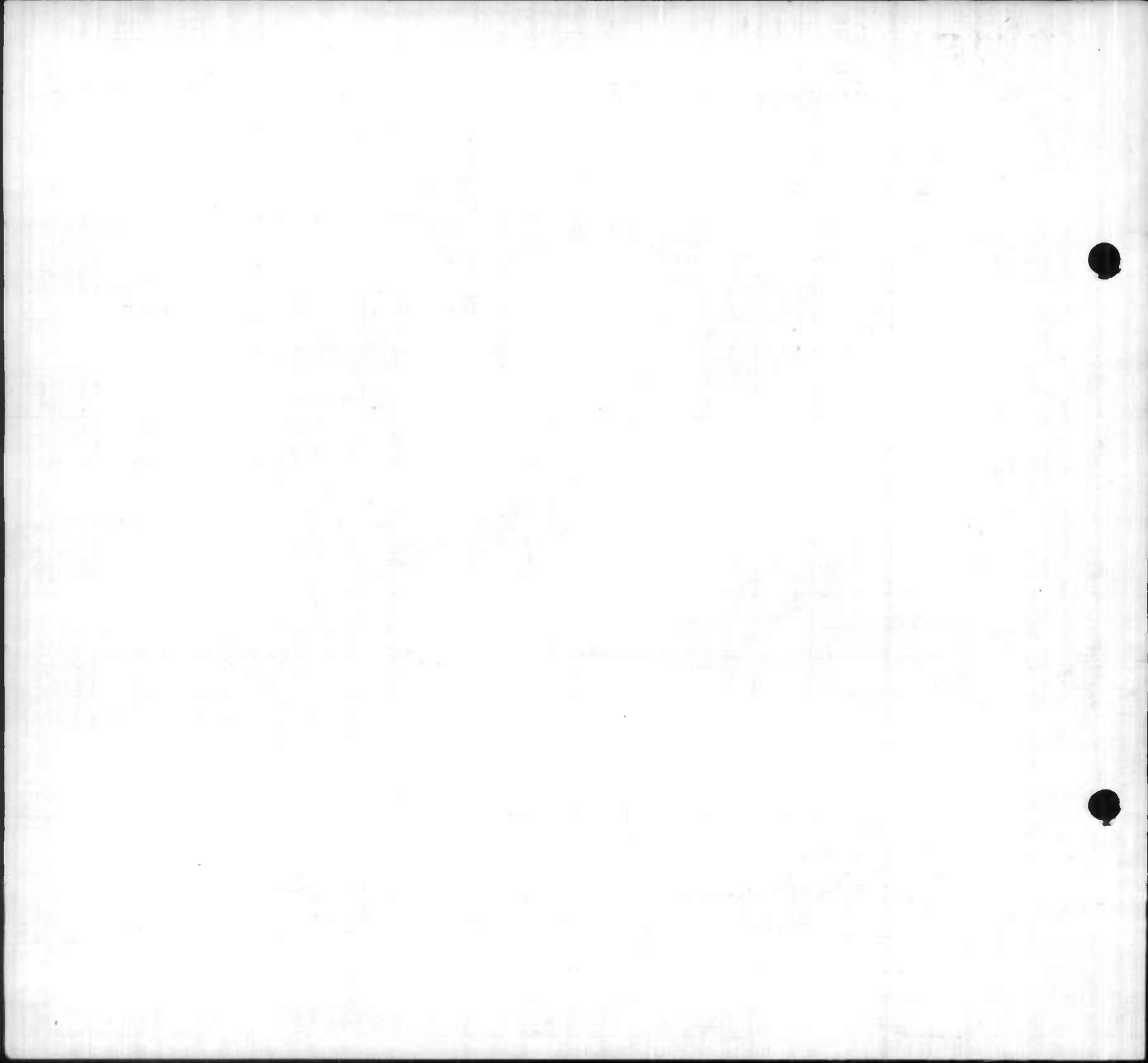
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1153</u> | |
|--|-------------------------|---|-------------------------------------|---|---|---|--|
| BIRTH NO. <u>65 1153</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Theresa Douglas</u> | | 2. DATE AND HOUR OF DEATH <u>1/30/65</u> <u>12:00 PM</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2610</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE CITY</u> D. STREET ADDRESS (If rural, give location) <u>3302 McELDERRY STREET</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>10-26-98</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOHN FOGEL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSA BARBERNITZ</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT ADDRESS <u>Rudolph Douglas 3302 McElberry St.</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Uremia & complete Anuria</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <u>Myocardial Infarction</u> DUE TO <u>ASCVD</u> | | <u>60 hours</u> | |
| | | | | (B) <u>DBI included lactic acidosis</u> DUE TO <u>prolongation</u> | | <u>72 hours</u> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>1/28</u> 19 <u>65</u> to <u>1/30</u> 19 <u>65</u> , that (1) <u>(we)</u> last saw the deceased alive on <u>1/30</u> 19 <u>65</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>J.R. Caldwell</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/30/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J.R. Caldwell</u> | | | | 23D. ADDRESS M.D. <u>Johns Hopkins Hospital Baltimore, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-3-65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u> | | 25C. FUNERAL DIRECTOR <u>B. DABROWSKI</u> | | ADDRESS <u>2818 E. BAY ST.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1154 | | | | |
| BIRTH NO. 65 1154 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Ella L. Loetz</u> | | | | | 2. DATE AND HOUR OF DEATH <u>29 JANUARY 1965 2:10 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> | | | | | A. STATE <u>Maryland</u> | | | | |
| | | | | | B. COUNTY <u>Baltimore</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Reisterstown 5300</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>8 Cherryhill Court</u> | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>October 15, 1885</u> | 9. AGE (In years last birthday) <u>79</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Richard Lintline</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Hoffman</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Leonard J. Doneski</u> | | | ADDRESS <u>8 Cherry Hill CT Reisterstown, Md</u> | | |
| 18. I <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Artery Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>24 January 1965</u> to <u>29 January 1965</u> , that (I) (we) last saw the deceased alive on <u>29 January 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>L.G. Tilley</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>29 January 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>L.G. Tilley</u> | | | | | 23D. ADDRESS M.D. <u>Maryland General Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/1/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>H. J. Schindt</u> | | ADDRESS <u>Owings Mills, Md.</u> | | | |



cdg: 32-40-95

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1155 | |
|---|--|---|--|--|--|
| BIRTH NO. 65 1155 | | CERTIFICATE OF DEATH | | Registered No. 65 1155 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Evelyn Smith | | January 29, 1965 12:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland Baltimore | | 26-36 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Female | | White | | Divorced | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 7-16-20 | | 44 | | USA | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| West Virginia | | USA | | Frank Rinehart | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Sara ? | | WW II | | 235343223 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | ADDRESS | |
| RECORDS: BCH 4940 Eastern Avenue 21224 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) Carcinoma of Cervix | | 2 1/2 years | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Left Kidney | |
| | | Perinephric Abscess, Non Functioning | | 3 months | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| D | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 13, 19 64 to January 29, 19 65, that (I) (we) last saw the deceased alive on January 28 29th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Jacinto Cruz | | | | 1-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| M.D. <i>Jacinto Cruz</i> | | | | M.D. 4940 Eastern Avenue 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-I-65 | | National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR | | ADDRESS | |
| Baltimore Md | | Valter Dabrowski | | 1005 Dundalk Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 1 1965 | | Robert E. Jarboe M.D. | | Valter Dabrowski | |

Letter from B.C.H.

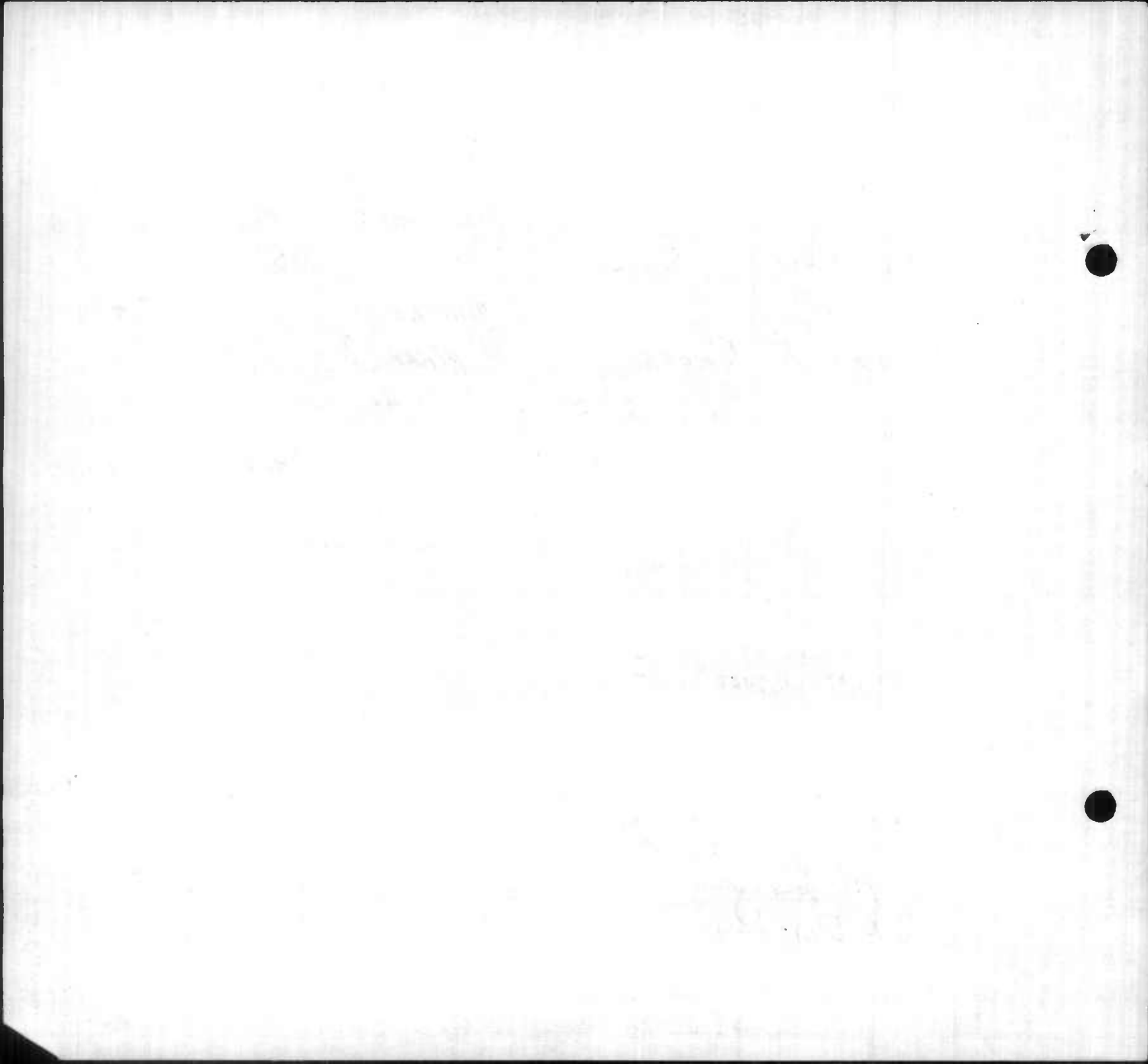
2-10-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1156 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1156 | |
|---|-------------------------|--|--|---|--|---|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) GROSS, HOWARD | | 2. DATE AND HOUR OF DEATH 2/1/65 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2108 WHATTIER AVE | | | | | |
| 5. SEX M | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 2-9-89 | 9. AGE (In years last birthday) 75 | 10. Under 1 Yr. Months: Days | | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM E GROSS | | | | 14. MOTHER'S MAIDEN NAME MARY ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 215-07-7049 | | 17. INFORMANT HOSPITAL CHART | | | |
| 18. 144 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CA OF SOFT PALATE DUE TO (B) MUCOSITIS OF THE ESOPHAGUS DUE TO 30 TO RADIOTHERAPY (C) _____ INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS | | | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIO SCLEROSIS | | | | | | | | | |
| 19A. DATE OF OPERATION 1/21/64 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TUBE GASTROSTOMY | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that he (this hospital) attended the deceased from 1/26/64 19 to 2/1/65 19, that he (we) last saw the deceased alive on 2/1/65 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE J.M. Diagonis | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE, SIGNED 2/1/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) J.M. DIACONIS | | | | 23D. ADDRESS M.D. UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-65 | | 24C. NAME of CEMETERY or CREMATORY Int Calvary Cem. | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR Spence & Peltz 1348 N. Calhoun St | | | | | |



65 1157

BALTIMORE CITY HEALTH DEPARTMENT

65 1157

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)J.
FRANCIS SULLIVAN, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

January 31, 1965 12:30 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1506 Medford Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

5/19/1937

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Coin Collector

10B. KIND OF BUSINESS OR INDUSTRY

C & P Telephone Co. Balto., Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank J. Sullivan

14. MOTHER'S MAIDEN NAME

Annie M. Flavin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-34-1977

17. INFORMANT

Frank J. Sullivan

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Ingleside Ave. & Social Security Blvd.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1 31 65 12:10A.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver/in auto-fire engine collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/4/1965

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1

1965

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.

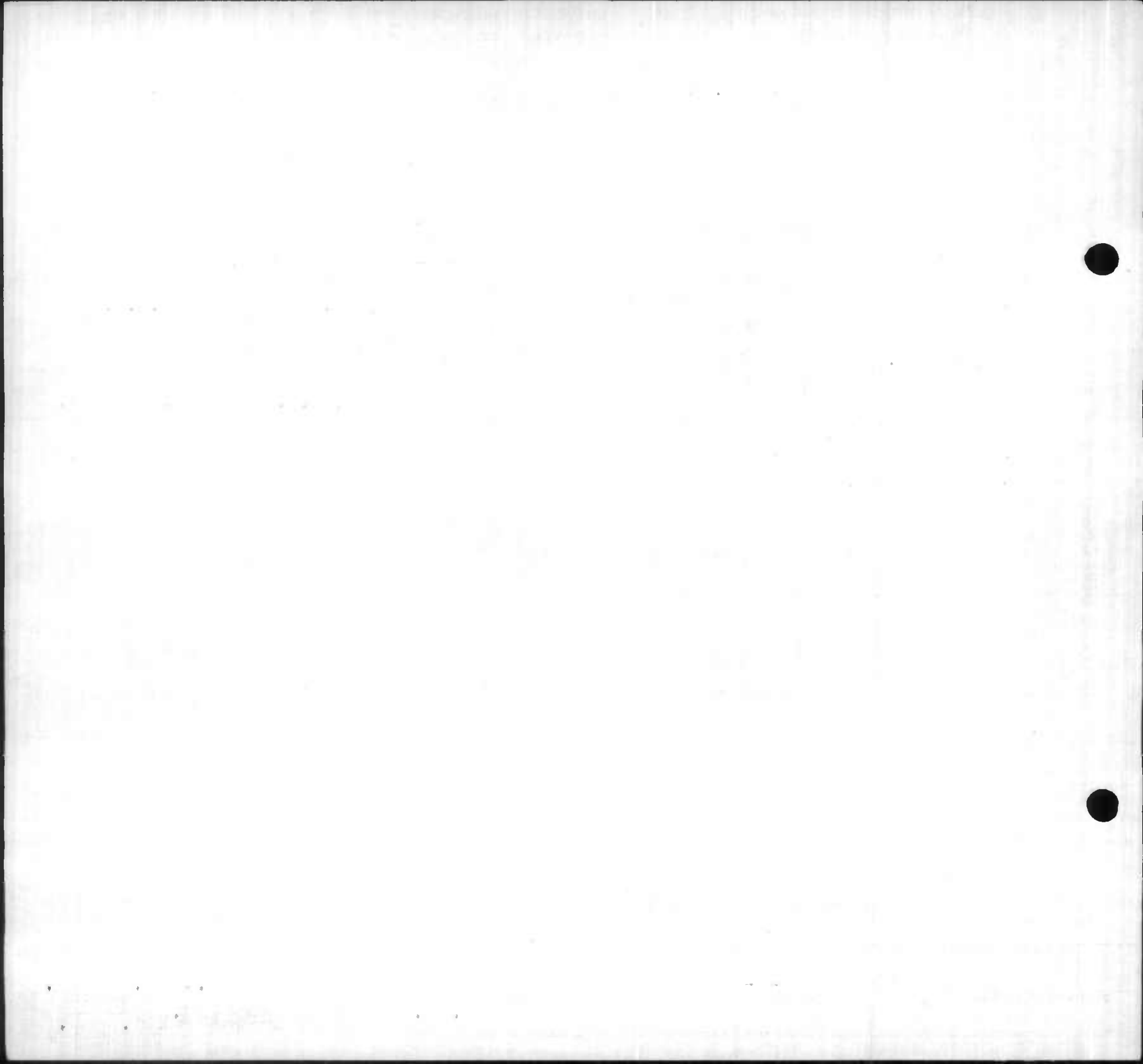
ADDRESS

WALLLEY RICHMOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

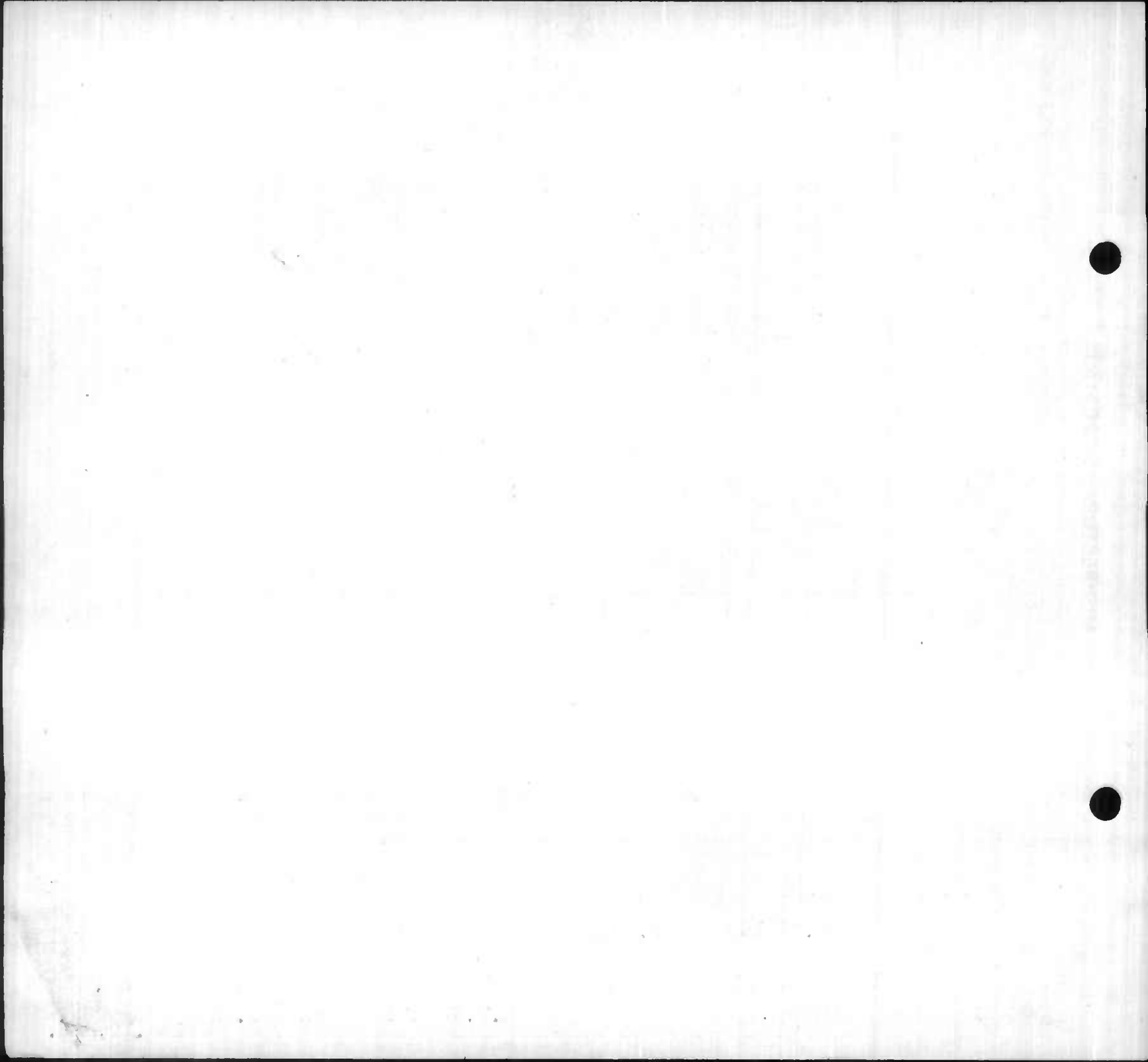
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1158 | |
|--|-----------------------------|--|--|--|--|
| BIRTH NO. 65 1158 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GARDNER, MRS. MABEL PUTTS | | | | 2. DATE AND HOUR OF DEATH 2/1/1965 - 8:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KESWICK | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) KESWICK D. STREET ADDRESS (If rural, give location) 700 W. 40th Street | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3-17-1883 | 9. AGE (In years last birthday) 81 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME J. William Putts | | | 14. MOTHER'S MAIDEN NAME Mary Meredith | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT ADDRESS Mary DiPaula, R.N. 700 W. 40th St. | | |
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Compensated Heart Failure Generalized atherosclerosis | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 wk. — |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-1-1965 to 2-1-1965 , that (I) (we) last saw the deceased alive on 2-1-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Hunter Wilson Jr. | | | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr. | | | | 23D. ADDRESS 803 Medical Arts Bldg., Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-1965 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn Balto., Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Road Balto. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

| BIRTH NO. | | 65 1159 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1159 | |
|--|---------|--|--|--|---------------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| BERTHA A. BYRNES | | | | JAN 31, 1965 16:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | | |
| | | | | B. COUNTY | | | |
| UNION MEMORIAL HOSPITAL | | | | MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 4426 WRENWOOD AVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| F | W | | | 4-10-86 | 78 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSE WIFE | | OWN HOME | | MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES H. BARNES | | | | MARTHA - HARBACK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | Chart - Union Mem. Hosp. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Cerebral hemorrhage | | 2.5 hrs and 10 min | |
| | | | | (B) Secondary to cerebral atherosclerosis | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II ARTERIOSCLEROTIC cardiovascular disease generalized | | | | (C) | | | |
| | | | | | | | |
| | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (4) (this hospital) attended the deceased from JAN 30 1965 to Jan 31 1965, that (1) (we) last saw the deceased alive on JAN 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Ellen Ann D. Millan | | | | | | Jan 31, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Ellen Ann D. Millan M.D. | | | | Union Memorial Hospital, Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2/3/1965 | | Baltimore Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| FEB 1 1965 | | Robert E. Farley, M.D. | | H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



65 1160

BALTIMORE CITY HEALTH DEPARTMENT

65 1160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANDREW MAXWELL

2. DATE AND HOUR PRONOUNCED DEAD

1-31-65

12:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

29 N. Eden Street 21231

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3-15-1897

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NC

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Maxwell

14. MOTHER'S MAIDEN NAME

Lucinda unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Clara Maxwell 29 N. Eden St.

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

DATE SIGNED

2-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Buried

23B. DATE

2-4-65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION

(City, town, or county)

(State)

A.C. County Md

24A. DATE REC'D BY HEALTH DEPT

FEB 1 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

ADDRESS

Joseph Knight 1639 N. Broadway

WALLACE FORGE

NOT CONTENT

100A

100B

100C

100D

100E

100F

100G

100H

100I

100J

100K

100L

100M

100N

100O

100P

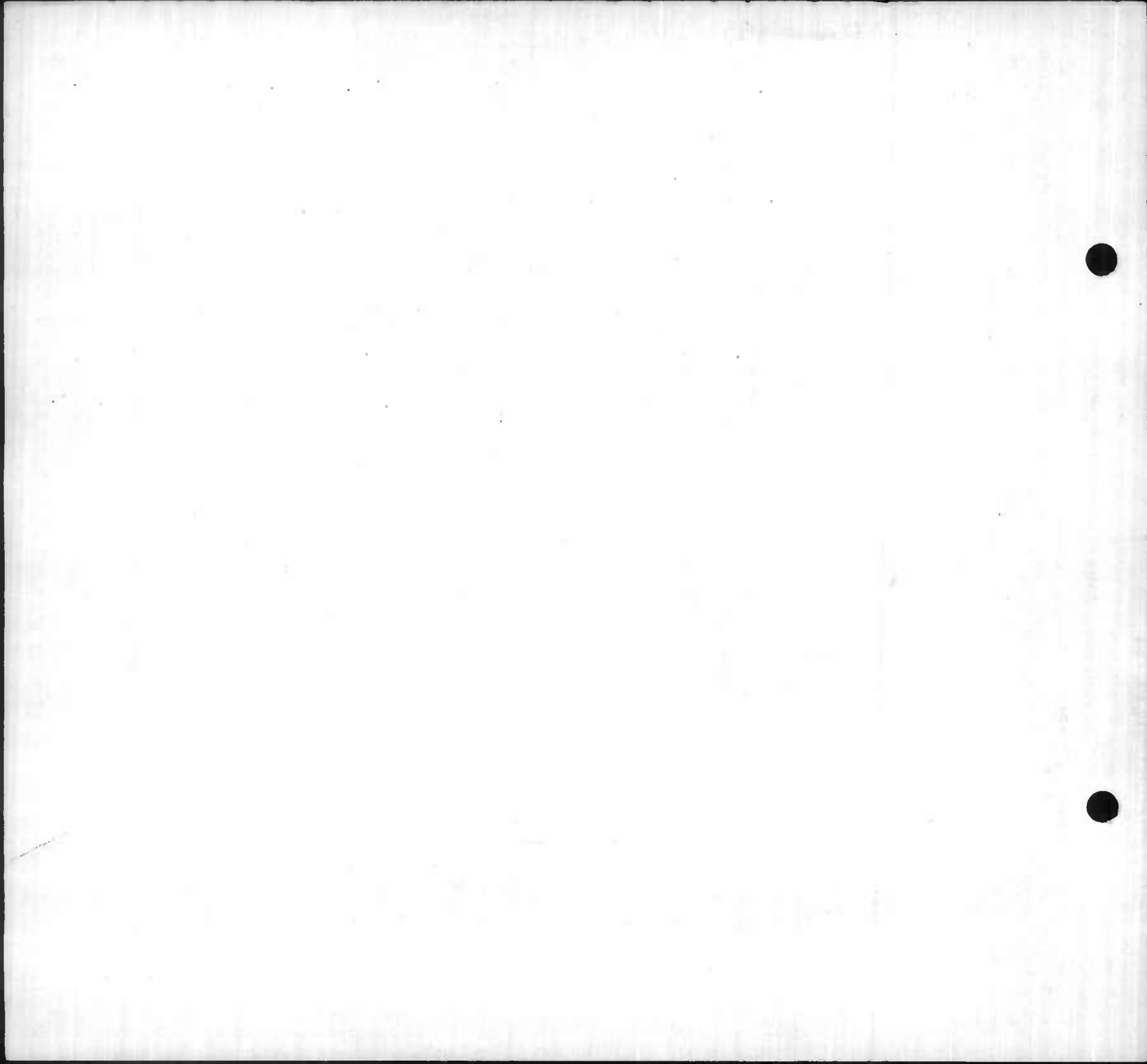
100Q

100R

100S

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

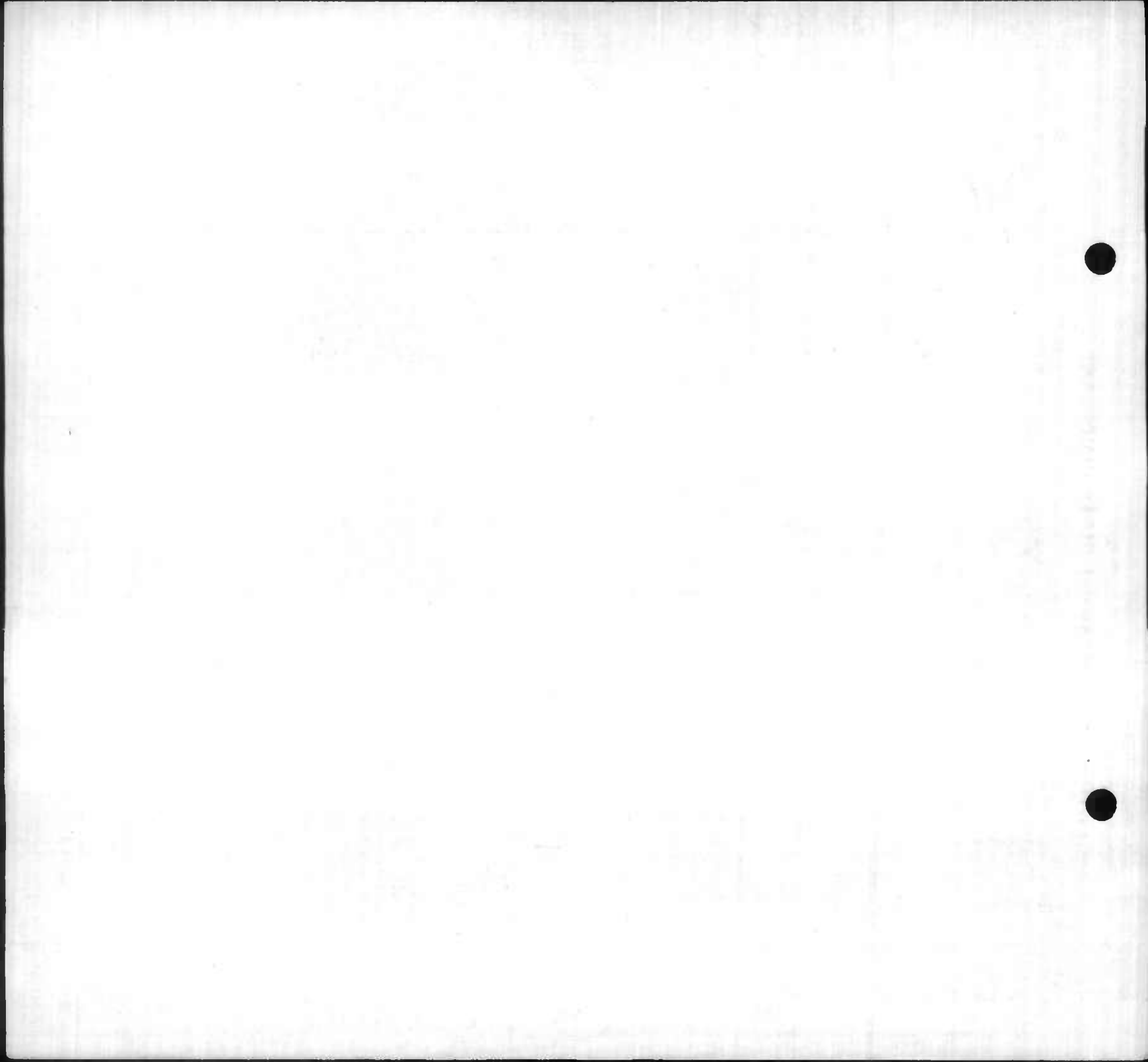
| BIRTH NO. 64-32883 | | | | 65 1161 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1161 | |
|---|--|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Anna M. Howard | | | | January 29. 1965 | | | | 5 ³⁰ /a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Maryland | | | | 27-10 | |
| 839 Belgin Ave. Balto. Md. | | | | B. COUNTY | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 839 Belgin Ave. | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Female | | White | | Baby | | 11/30/1964 | | 1 30 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | |
| N/A | | | | N/A | | | | Maryland | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| Donald G. Howard | | | | Pauline E. Crim | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| N/A | | | | N/A | | Sarah B. Crim 3528 Buena Vista Ave. | | | |
| 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | | Pneumonia | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | 2 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| O | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 26 1965 to Jan. 29 1965 that (I) (we) last saw the deceased alive on Jan. 26 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Reuben Hoffman | | | | 1-29-65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| REUBEN HOFFMAN | | | | 846 W. 36th St., BALTO., MD. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 1/30/1965 | | Green hill | | Berryville, Clark Co. Va. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | |
| FEB 2 1965 | | Robert E. Taylor, M.D. | | Frank X. Seitz | | | | 814 W 36th St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1162 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1162 | |
|--|---------------------------|--|---|---|---|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Clinton Jackson</i> | | 2. DATE AND HOUR OF DEATH <i>1-28-1965 10:00 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>12-04</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Joseph's Hospital</i> | | D. STREET ADDRESS (If rural, give location) <i>428 E. 22nd St.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>April 11, 1908</i> | 9. AGE (In years last birthday) <i>56</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Construction</i> | | 11. BIRTHPLACE (State or foreign country) <i>Chesterfield, S.C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Joe Jackson</i> | | 14. MOTHER'S MAIDEN NAME <i>Mahilia Jacobs</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Bessie Jackson-2917 W. North Ave.</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTÉCEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Acute Coronary Thrombosis instant</i> DUE TO (B) <i>Coronary insufficiency 3-4 mo.</i> DUE TO (C) <i>A.C.U.D.</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-2-1</i> 196 <i>5</i> to <i>1-28-</i> 196 <i>5</i> , that (I) (we) last saw the deceased alive on <i>1-28-</i> 196 <i>5</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Hiroshi Nakazawa</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>1-29-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>HIROSHI NAKAZAWA</i> | | M.D. 23D. ADDRESS <i>521 W. Lexington St. #1</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1-2-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i> | |
| 24D. LOCATION <i>BALTO. - Md.</i> | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>MARSHALL W. JONES, JR.</i> | |
| 25D. ADDRESS <i>1735 HARFORD AVE.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1163 | |
|--|-----------------|--|---|--|---|
| BIRTH NO. 65 1163 | | M.E. CASE NO. | | 1 | |
| 1. NAME OF DECEASED (Type or Print) Charles Harper | | | 2. DATE AND HOUR OF DEATH 1/28/65 10:00 p. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of place where death occurred) CERTIFICATE CORRECTED 2/3/65 South Baltimore General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 22-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 726 S. Hanover Street | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 11/28/1907 | 9. AGE (In years last birthday) 57 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME Edward Harper | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 340.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumococcal Meningitis (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 1/27/65 19 to 1/28/65 19, that (X) (we) lost saw the deceased alive on 1/28/65 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kermit P. Bonovich M.D. | | | | 23B. DATE SIGNED 1-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) KERMIT P. BONOVICH, M.D. | | | 23D. ADDRESS Dr. Kermit P. Bonovich 1213 Light St. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-65 | | 24C. NAME OF CEMETERY OR CREMATORY Greenville North Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR G. W. Wainwright 2700 Edmondson Ave | |

VS 153 signed by funeral director. 2/3/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department CERTIFICATE OF DEATH | | | | Registered No. 65 1164 | |
|---|---------------------|--|--------------------------------------|--|--|
| BIRTH NO. 65 1164 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MR. Wellington JEFFERSON | | 2. DATE AND HOUR OF DEATH Jan 31 1965 10625 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND Gen. Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 4208 COTTMAN AVE. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED/NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-15-1904 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY LUNCH ROOM. | | 11. BIRTHPLACE (State or foreign country) N.Y. | |
| 12. CITIZEN OF WHAT COUNTRY? US | | | | | |
| 13. FATHER'S NAME Guy Jefferson | | 14. MOTHER'S MAIDEN NAME GRACE Heblan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MRS. MARGARET JEFFERSON 4208 COTTMAN AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 491 X I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRO NCHOPNEUMONIA | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PULMONARY EMPHYSEMA; HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 29 1965 to Jan 31 1965 , that (I) (we) last saw the deceased alive on Jan 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Youngsik Moon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Jan 31, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNGSIK MOON | | 23D. ADDRESS M.D. Maryland Gen. Hosp. 8272 Linden Ave. Balto | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY MORELAND MEMO PARK | |
| 24D. LOCATION PARKVILLE MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS United Funeral Home Pelaw & Pikeside 501 Niles | |

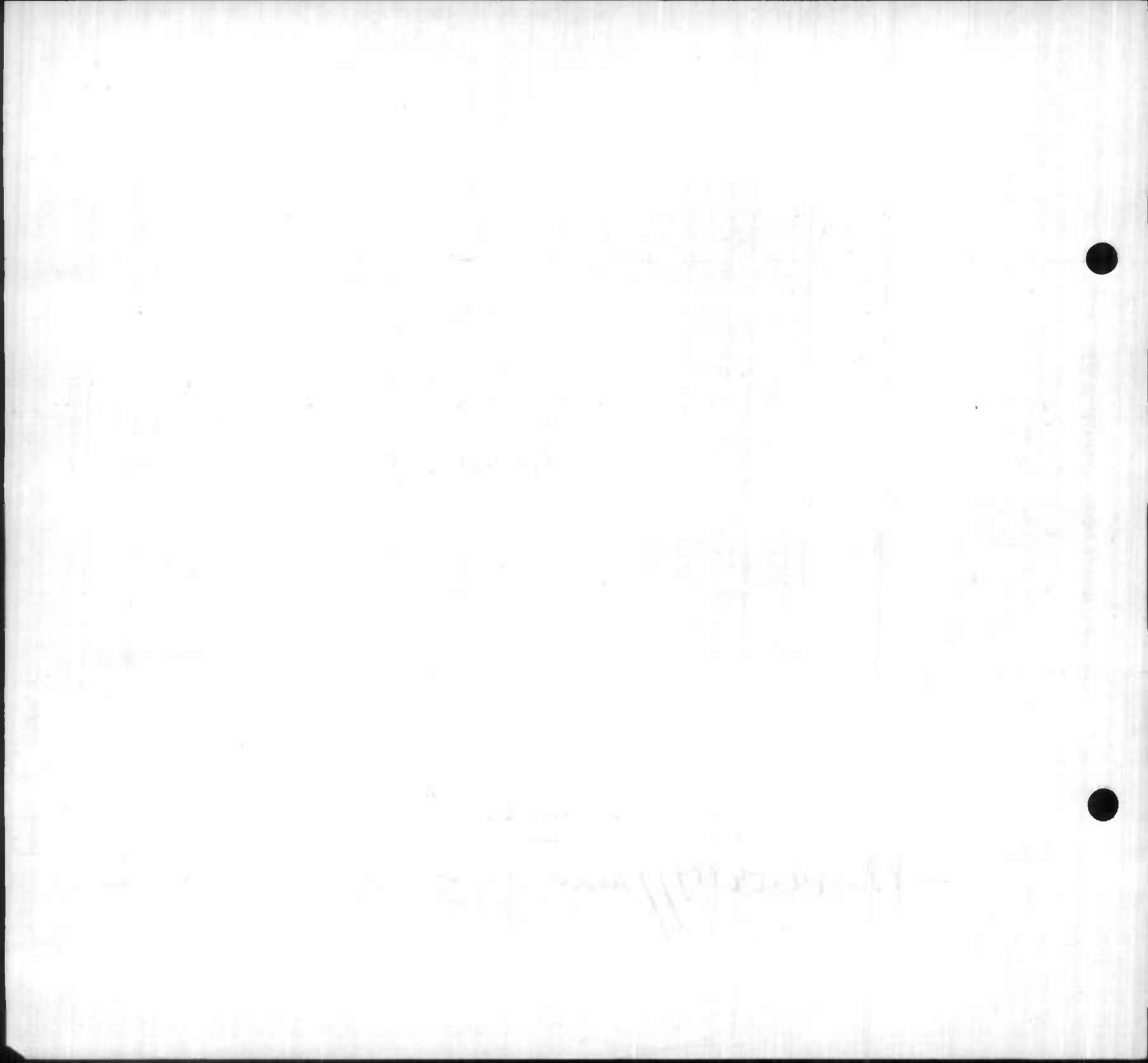
1. 1/2 inch wide strip

2. 1/2 inch wide strip
3. 1/2 inch wide strip
4. 1/2 inch wide strip
5. 1/2 inch wide strip
6. 1/2 inch wide strip
7. 1/2 inch wide strip
8. 1/2 inch wide strip
9. 1/2 inch wide strip
10. 1/2 inch wide strip

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1165 | |
|--|------------------|--|------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1165 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Lillie Muhlhan | | 2. DATE AND HOUR OF DEATH January 28, 1965 5 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Melchor Nursing Home 2327 N. Charles St., | | A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2527 Eastern Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH April 28, 1884 | 9. AGE (In years last birthday) 80 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John M. Bensel | | 14. MOTHER'S MAIDEN NAME Margaret Kopp | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-07-3129 | | 17. INFORMANT Mrs. Marguerite M. Savers, Pepper Hill Rd. Md. | |
| 18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebral Arteriosclerosis DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH Indefinite | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1962 to 28 Jan 1965 that (I) (we) last saw the deceased alive on 28 Jan 65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John B. De Hoff | | 23B. DATE SIGNED 30 Jan 65 | | 23C. PHYSICIAN'S NAME (Type) John B. De Hoff | |
| 23D. ADDRESS Northern Pkwy. & Loch Raven Blvd. | | 23E. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | |
| 23F. NAME OF REGISTRAR Robert E. Farley | | 23G. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road. | | | |
| 23H. ADDRESS | | 23I. DATE | | | |
| 23J. NAME OF CEMETERY or CREMATORY First United Evan. Cemetery | | 23K. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |



42-72-54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1166

BIRTH NO. 65 1166

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ruth Epperson

2. DATE AND HOUR OF DEATH

January 29, 1965

8:05

A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2820 Salisbury Avenue 21219

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7-7-1911

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Missouri

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Burris

14. MOTHER'S MAIDEN NAME

Opal Bailey

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 260x I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Probable Myocardial Infarction

1 Hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Diabetes Mellitus

? Years

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 29, 19 65 to January 29, 19 65,
that (I) (we) last saw the deceased alive on January 29, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Robert Cooke

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-29-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Robert Cooke

23D. ADDRESS

M.D.

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

removal

24B. DATE

Jan 30/65

24C. NAME OF CEMETERY or CREMATORY

Davis Family Cemetery

24D. LOCATION

(City, town, or county)

Campbell Co Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

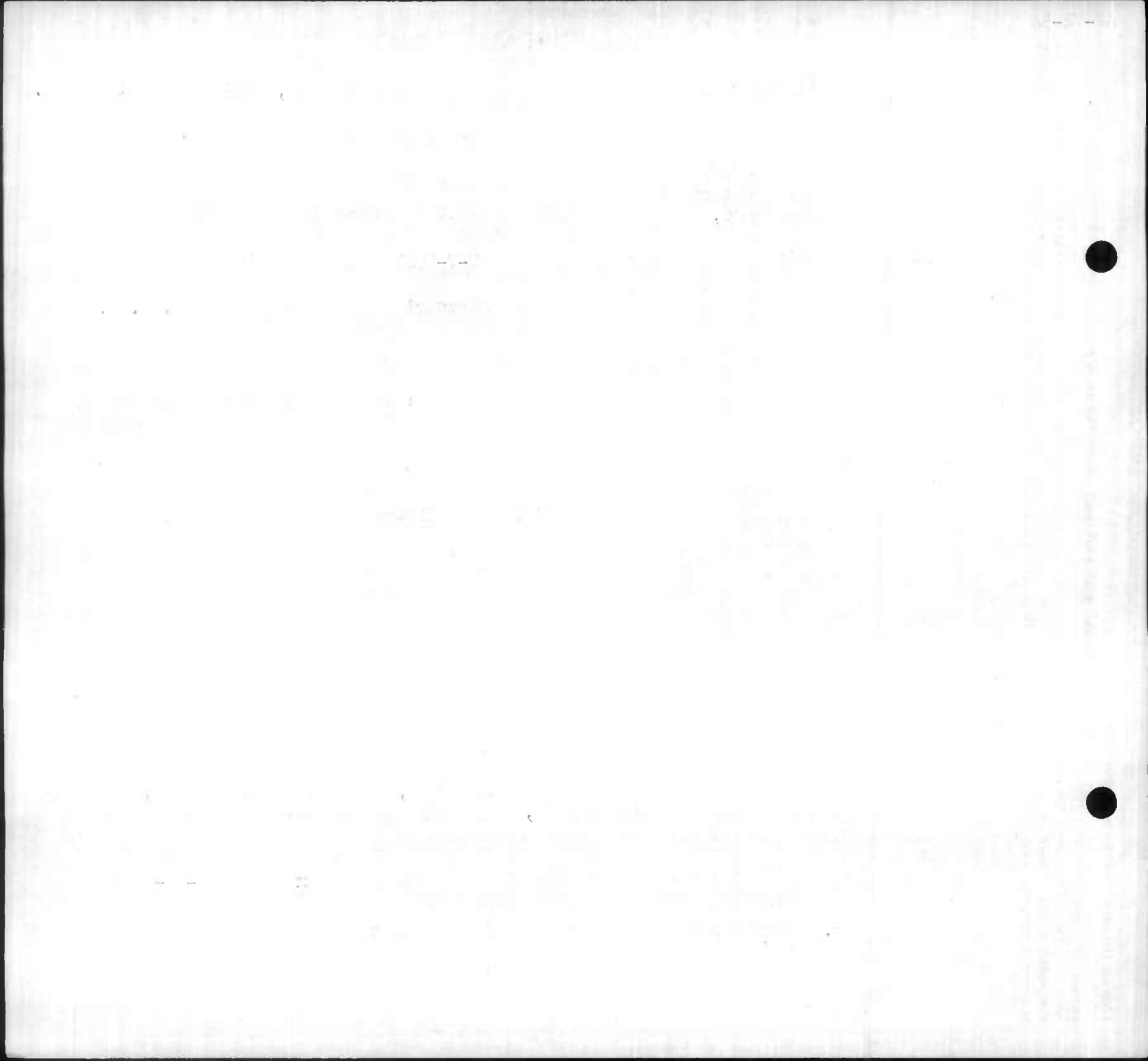
25C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

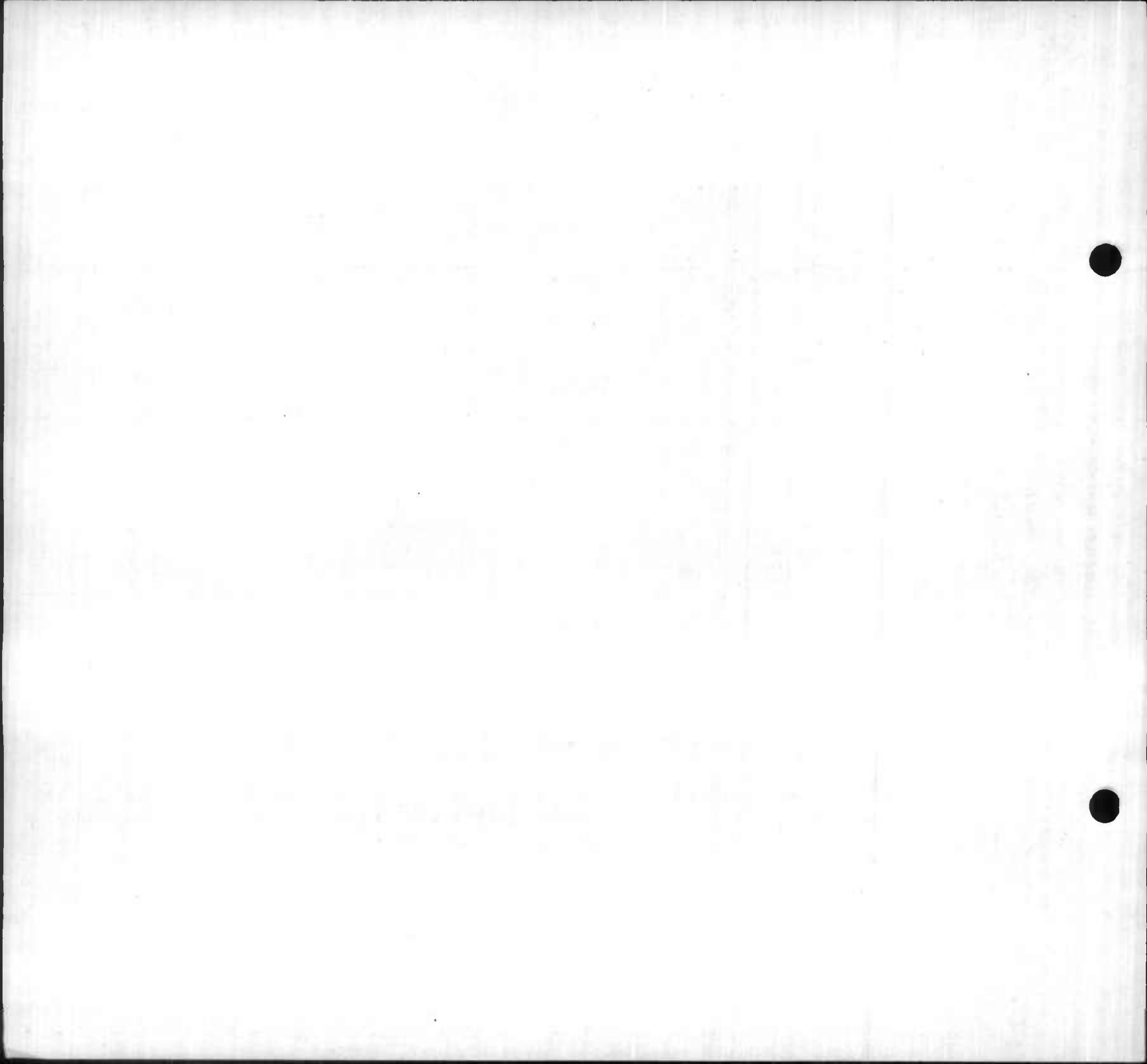
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

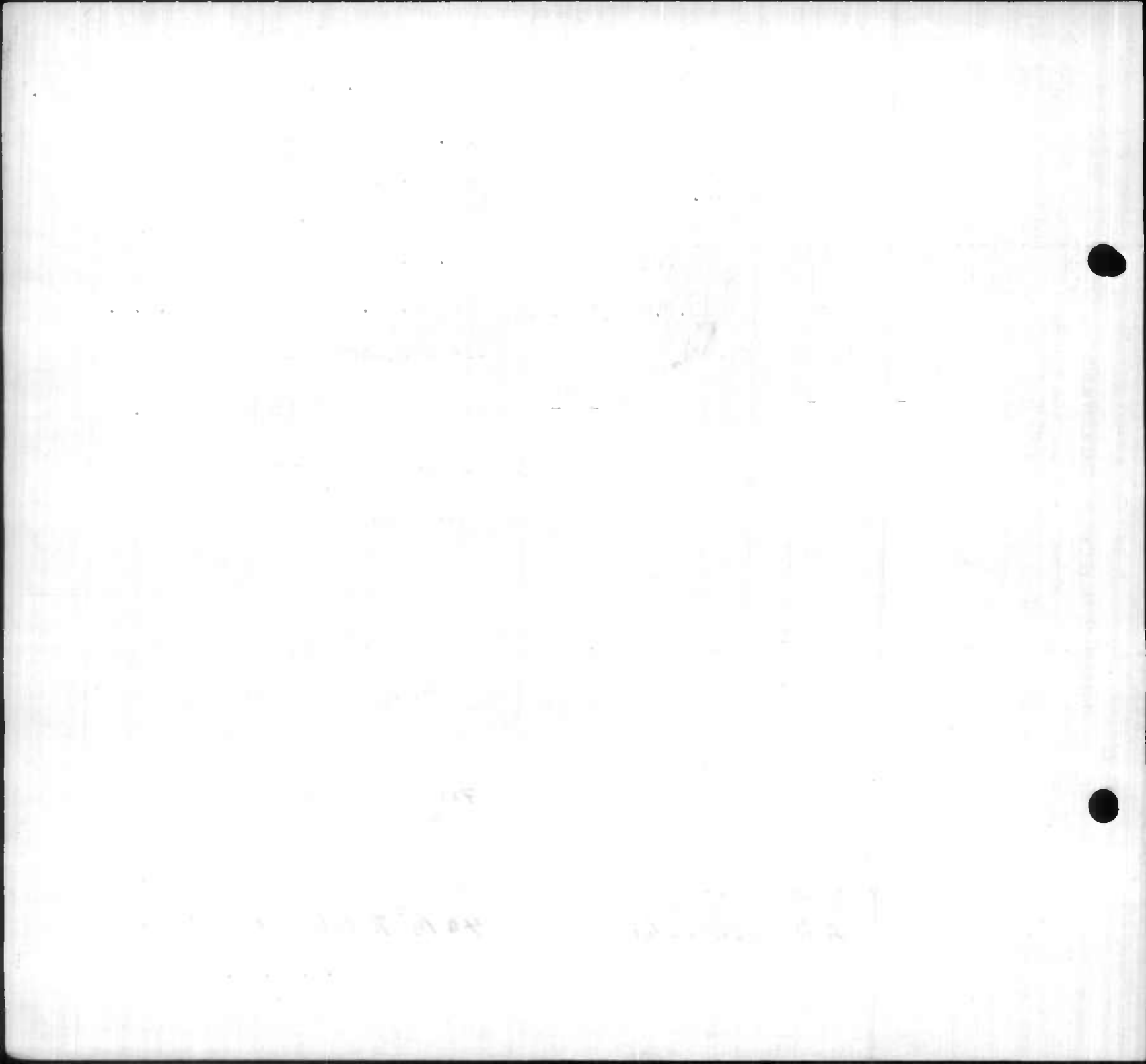
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|---|--|--|--|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1167</u> | | | | |
| BIRTH NO. <u>65 1167</u> | | | | | 2. DATE AND HOUR OF DEATH <u>January 28, 1965</u> M. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Laura V. Andrae</u> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4220 White Ave.</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2601</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4220 White Ave.</u> | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Sept. 18, 1875</u> | 9. AGE (In years last birthday) <u>89</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Augustus Klages</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Ellen Meyers</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. Evelyn Andrae 4220 White Ave.</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral thrombosis</u> DUE TO <u>Arteriosclerotic Cerebral Vascular disease</u> DUE TO <u>disease</u> DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January 19 59</u> to <u>January 28 19 65</u> , that (I) (we) last saw the deceased alive on <u>January 28 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Paul G. Mueller</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <u>1/29/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Paul G. Mueller</u> | | | | | 23D. ADDRESS M.D. <u>6411 Belair Road</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/30/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>Ullrich Funeral Home 4210 Belair Road.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1168</u> | |
|--|-------------------------|---|--|--|--|--|--------------------------------|
| BIRTH NO. <u>65 1168</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Frank Gwalina</u> | | | | 2. DATE AND HOUR OF DEATH <u>Jan. 30, 1965</u> <u>5 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>1005 Church St.</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Md.</u> | | B. COUNTY <u>25-05</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto. City</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>1005 Church St. Zone 26</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>Jan. 30, 1905</u> | 9. AGE (In years last birthday) <u>60</u> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Quaterman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Coast Guard</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Bernard Gwalina</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Korwoski</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>218-42-4042</u> | | 17. INFORMANT ADDRESS <u>Mary Gwalina 1005 Church St.</u> | | | |
| 18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Bronchogenic carcinoma</u> DUE TO (B) <u>C. metastasis</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1964</u> to <u>30 Jan 65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>27 Jan 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>A.R. Sosnowski</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>1 Feb 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A.R. Sosnowski</u> | | | | 23D. ADDRESS M.D. <u>4016 Ritchie Hwy Balt. 25 Md</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/3/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Cross</u> | | 24D. LOCATION (City, town, or county) (State) <u>A.A.Co.Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fairley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Wm. S. F. Kalowski</u> | | ADDRESS <u>2007 Eastern Ave</u> | |



cdg: 42-71-30

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1169

| | | | |
|--|------------------|---|-----------------------------|
| BIRTH NO. 65 1169 | | 2. DATE AND HOUR OF DEATH January 31, 1965 6:00 PM. | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Devilla Jones | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1134 N. Stricker Street | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-12-97 |
| 9. AGE (In years last birthday) 68 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Bates | | 14. MOTHER'S MAIDEN NAME Sarah Stewart | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Arteriosclerotic Cardio Vascular Accident DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Pylonephritis | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 12, 1965 to January 31, 1965, that (I) (we) last saw the deceased alive on January 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE R. Cooke | | 23B. DATE SIGNED 1-31-65 | |
| 23C. PHYSICIAN'S NAME (Type) Robert Cooke | | 23D. ADDRESS 4940 Eastern Avenue 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR Charles R. Law | | ADDRESS 802 Madison Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

60

75

100

125

150

175

200

225

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275

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525

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575

600

625

650

675

cdg: 41-93-60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 1170

65 1170

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John J. Lord

2. DATE AND HOUR OF DEATH

January 29, 1965

5:30 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland St. Mary's Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Chaptico, Maryland

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1-11-19

9. AGE (In years
last birthday)

45 46

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry W. Lord

14. MOTHER'S MAIDEN NAME

Margaret Chambers

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-30-9291

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 592 X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Acute Pulmonary Edema
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

24 hours

(B) Uremia
DUE TO

1 1/2 years

(C) Chronic Glomerulonephritis

years

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 23, 1964 to January 29, 1965,
that (I) (we) last saw the deceased alive on January 29, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-29-65

23C. PHYSICIAN'S
NAME (Type)

Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-1-1965

24C. NAME OF CEMETERY or CREMATORY

St. Louis

24D. LOCATION

(City, town, or county)

Clarksville, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

25B. NAME OF REGISTRAR

Robert E. Tabor, M.D.

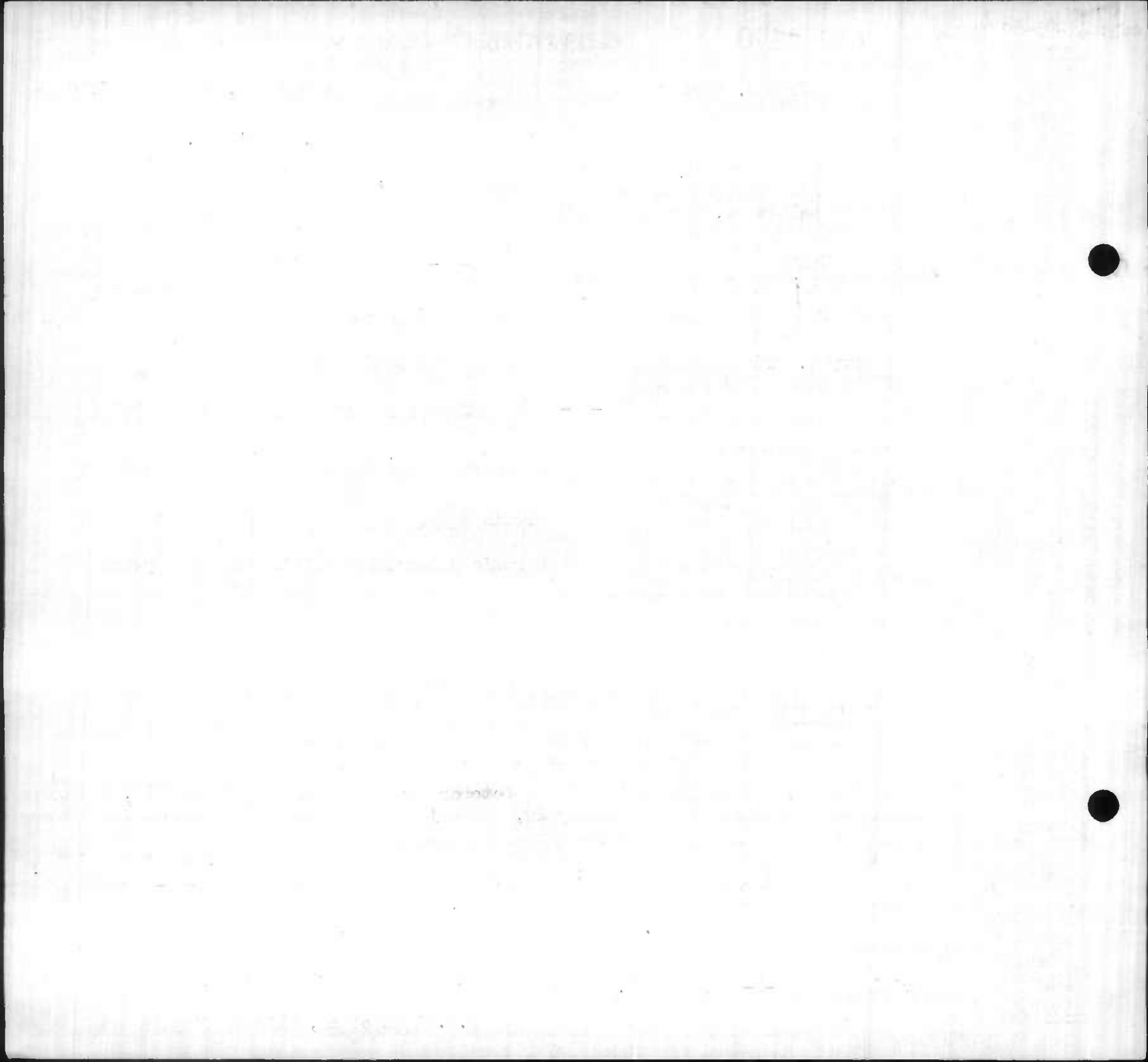
25C. FUNERAL DIRECTOR

F.C. Higginbotham, Ellicott City, Md

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

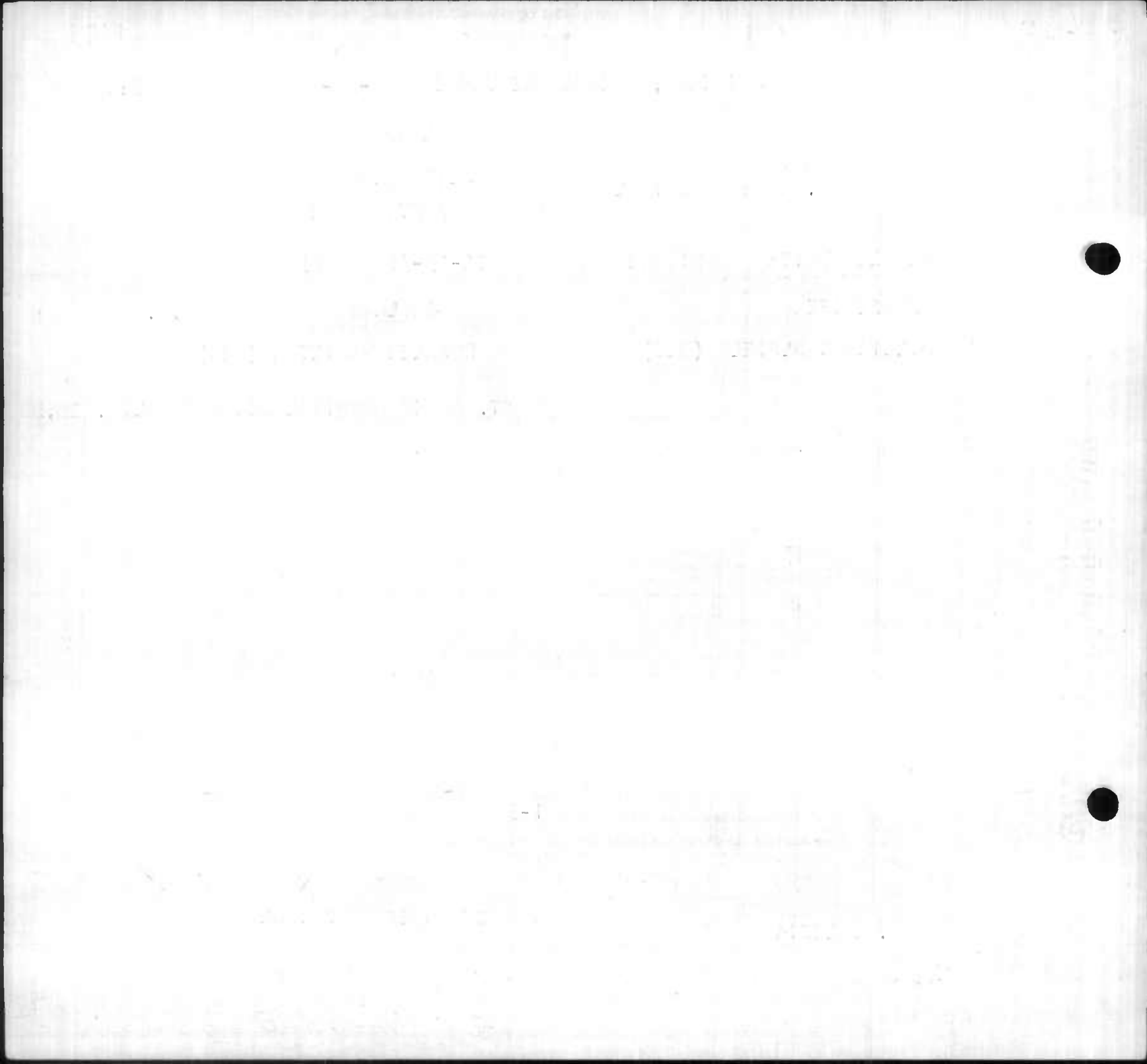


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M.630 1

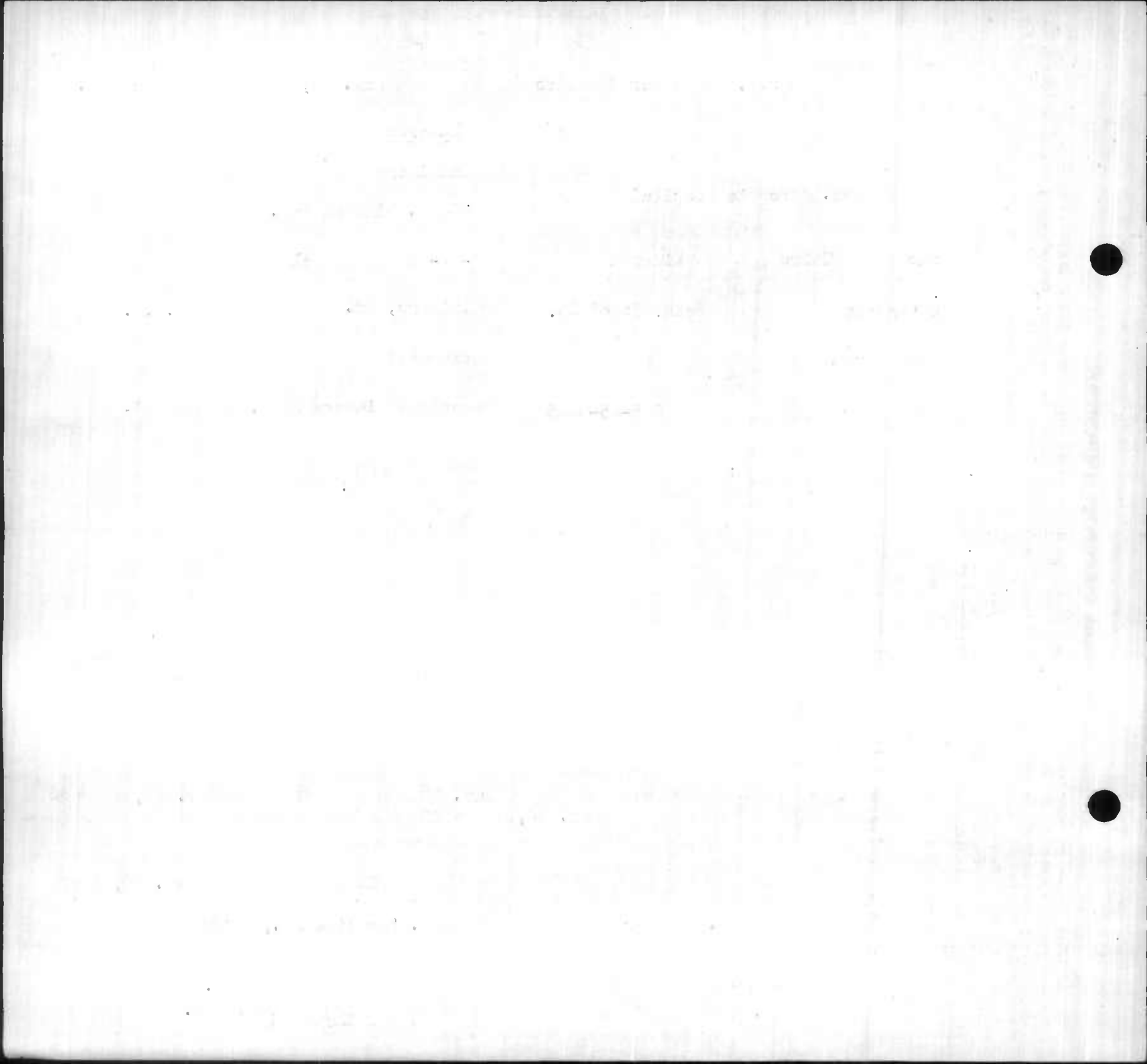
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. <u>65 1171</u> | |
|---|-------------------------|---|--|--|--|--|--|---|--|------------------------------------|--|
| BIRTH NO. <u>65 1171</u> | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | <u>MOOREHEAD, EDNA GERTRUDE</u> | | | | | | 2. DATE AND HOUR OF DEATH | | <u>1-30-65 3:15 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto</u> | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | | | | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>17 FUSTING AVENUE</u> | | | | | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | | 8. DATE OF BIRTH <u>12-23-91</u> | | 9. AGE (In years last birthday) <u>73</u> | | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13. FATHER'S NAME <u>WILLIAM CAULFIELD (DEC)</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSALEE HAMILTON (DEC)</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS BALTO. 29, MD</u> | | | | ADDRESS | | | |
| 18. <u>199.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Abdominal Carcinomatosis</u> | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO | | | | | | | | | |
| (C) DUE TO | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-29 1965</u> to <u>1-30 1965</u> , that (I) (we) last saw the deceased alive on <u>1-30 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Wenfredo Iglesias</u> M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1-30-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. IGLESIA</u> | | | | 23D. ADDRESS <u>ST AGNES HOSPITAL</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/5/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>E. S. MACNABB</u> | | ADDRESS <u>3017 FREDERICK RD 21228</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

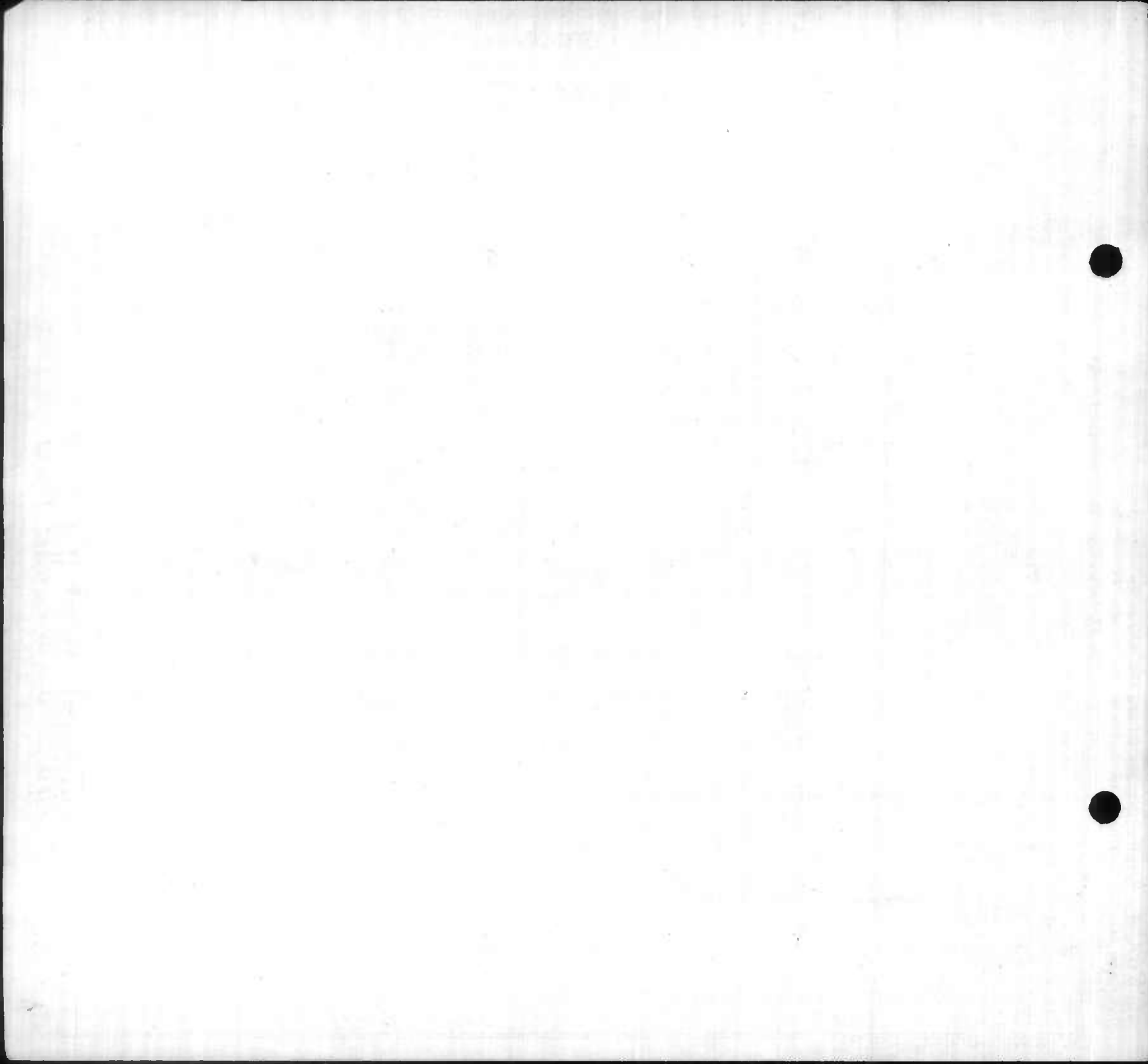
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|---|--|---|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1172 | | | | | | |
| BIRTH NO. 65 1172 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Garey, Alexander Ignatius | | | | | 2. DATE AND HOUR OF DEATH Jan. 30, 1965 10:55 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 6-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #24 D. STREET ADDRESS (If rural, give location) 204 N. Linwood Ave. | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 4-27-83 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Suptendant | | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John Garey | | | | | 14. MOTHER'S MAIDEN NAME Susan Heil | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 215-05-5245 | | 17. INFORMANT ADDRESS Magdalena Sinners 25 N. Clinton St. | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | (A) Carcinoma of lungs DUE TO | | | | | | |
| | | | | | (B) DUE TO | | | | | | |
| | | | | | (C) DUE TO | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 20 19 65 to Jan. 30 , 19 65 , that (I) (we) last saw the deceased alive on Jan. 30 , 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED Jan. 30, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) William B. VandeGrift | | | | | 23D. ADDRESS M.D. 1400 N. Caroline St., 21213 | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | | ADDRESS 3331 Brenns Lane #13 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 1173 | | CERTIFICATE OF DEATH | | Registered No. 65 1173 | |
|---|---------------------------|--|--|--|--|--|--|--|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print) ARTHUR BOBBITT | | | | 2. DATE AND HOUR OF DEATH 1/31/65 10 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2706 LAURETTA | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2706 LAURETTA AVE | | | | | |
| 5. SEX M | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5/14/1888 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSEMAN | | | 10B. KIND OF BUSINESS OR INDUSTRY FARM EQUIPMENT SUPPLY | | | 11. BIRTHPLACE (State or foreign country) GASTONIA - N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS BOBBITT | | | | 14. MOTHER'S MAIDEN NAME SUDIE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 21-3-03-6757 | | 17. INFORMANT MARY BOBBITT | | | ADDRESS 2706 LAURETTA AVE |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 442X1 | | | | CAUSE OF DEATH (A) DUE TO Respiratory Failure (B) DUE TO Respiratory & Circulatory (C) DUE TO Cordis bronchovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 13 1965 to 1/31 1965 , that (I) (we) last saw the deceased alive on Jan 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE S. Borofsky | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) S. Borofsky | | | | 23D. ADDRESS M.D. 6017 N. Moore Rd. Baltimore | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 2/4/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | | 24D. LOCATION (City, town or county) (State) Baltimore | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Marshall P. Hayes | | | ADDRESS 685 N. Glen Ave. SE |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1174 | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 65 1174 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Sidney J. Burgunder</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>January 31, 1965</u> <u>11:15 p.</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-20</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>7121 Park Heights Ave. Apt #204</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>8-21-92</u> | 9. AGE (In years last birthday) <u>72</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>LUGGAGE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>JOSEPH J. BURGUNDER</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>THERSA GUNDSHEIMER</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW1</u> <u>NAVY</u> | | | |
| 16. SOCIAL SECURITY NO. <u>212-01-3948</u> | | 17. INFORMANT <u>MRS. MILDRED BURGUNDER 7121 PARK HEIGHTS AVE</u> | | | |
| 18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Cerebrovascular Accident</u> DUE TO (B) <u>Arteriosclerotic Cerebrovascular disease</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>9 weeks</u> <u>5 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>November 29</u> 19 <u>64</u> to <u>January 31</u> 19 <u>65</u> , that (I) was last saw the deceased alive on <u>January 31</u> 19 <u>65</u> and that in (my) was opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Harry M. Charkatz</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1-31-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Harry M. Charkatz</u> | | 23D. ADDRESS M.D. <u>Sinai Hospital of Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/2/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u> | | | |

Male Male

8-21-25

Billings

Billings

Billings

Billings

Billings

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Billings

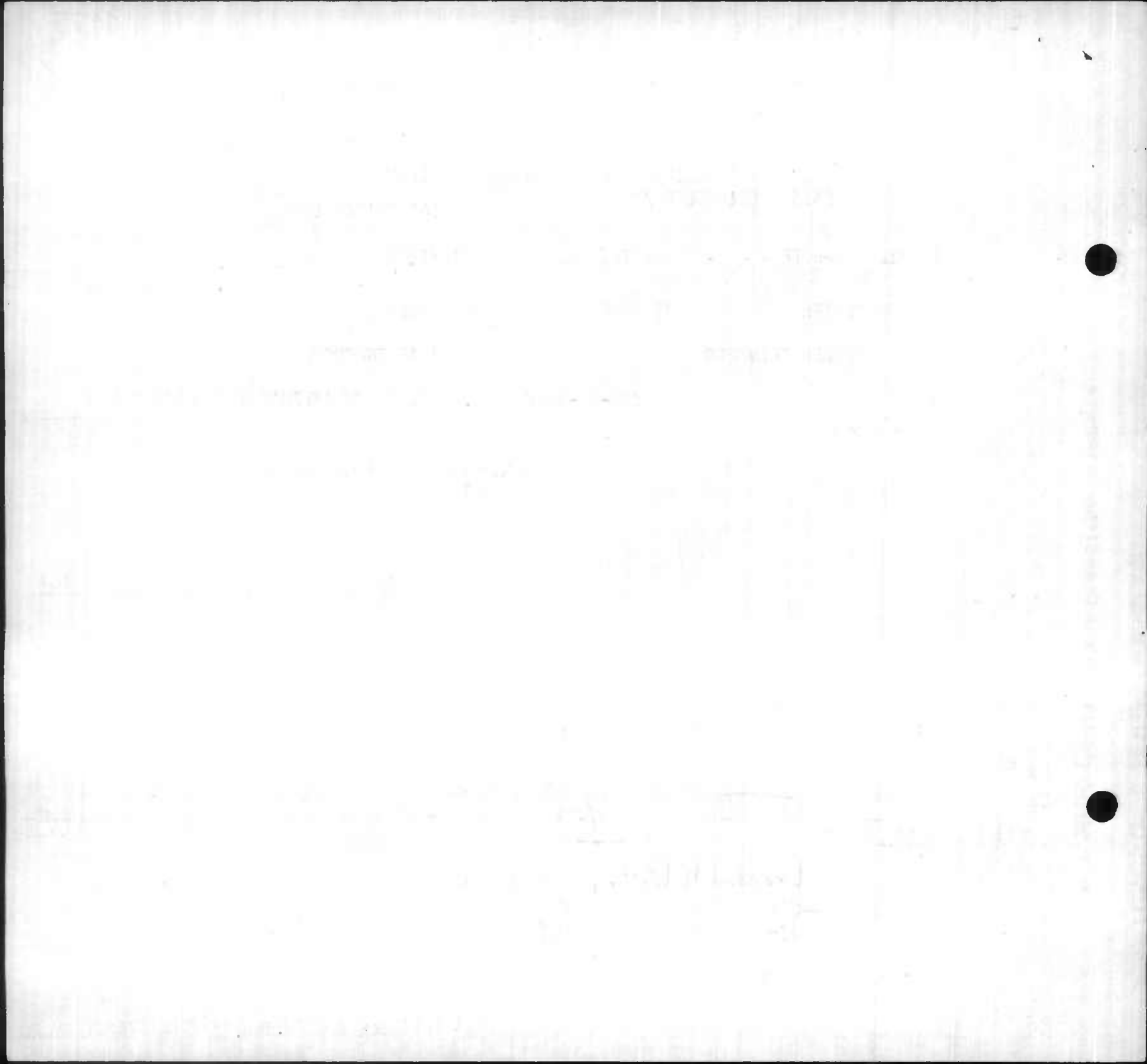
Harry M. Charles

Billings

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. | |
|--|-------------------------|--|--------------------------------------|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | 65 1175 | |
| BIRTH NO. 65 1175 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GOLDIE SCHWARTZMAN | | 2. DATE AND HOUR OF DEATH JANUARY 30, 1965 6 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME 2525 W BELVEDERE AVE | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 27-20 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3805 CLARKS LANE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5/12/1896 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME SENDER FEINBERG | | | | 14. MOTHER'S MAIDEN NAME KATIE THEODORE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-09-5560 | | 17. INFORMANT ADDRESS MR. PHILIP SCHWARTZMAN 3805 CLARKS LANE | | | |
| 18. 309X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Chronic cerebral deterioration ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/28 19 65 to 1/30 19 65 and that (I) (we) lost saw the deceased alive on 1/28 19 65 and that in (my) (our) opinion death occurred on the date 1/30/65 and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Leonard M. Hister M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) Ronald M. Hister M.D. | | | | 23D. ADDRESS 7121 Park Heights Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



1
v. 214

65 1176

BALTIMORE CITY HEALTH DEPARTMENT

65 1176

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

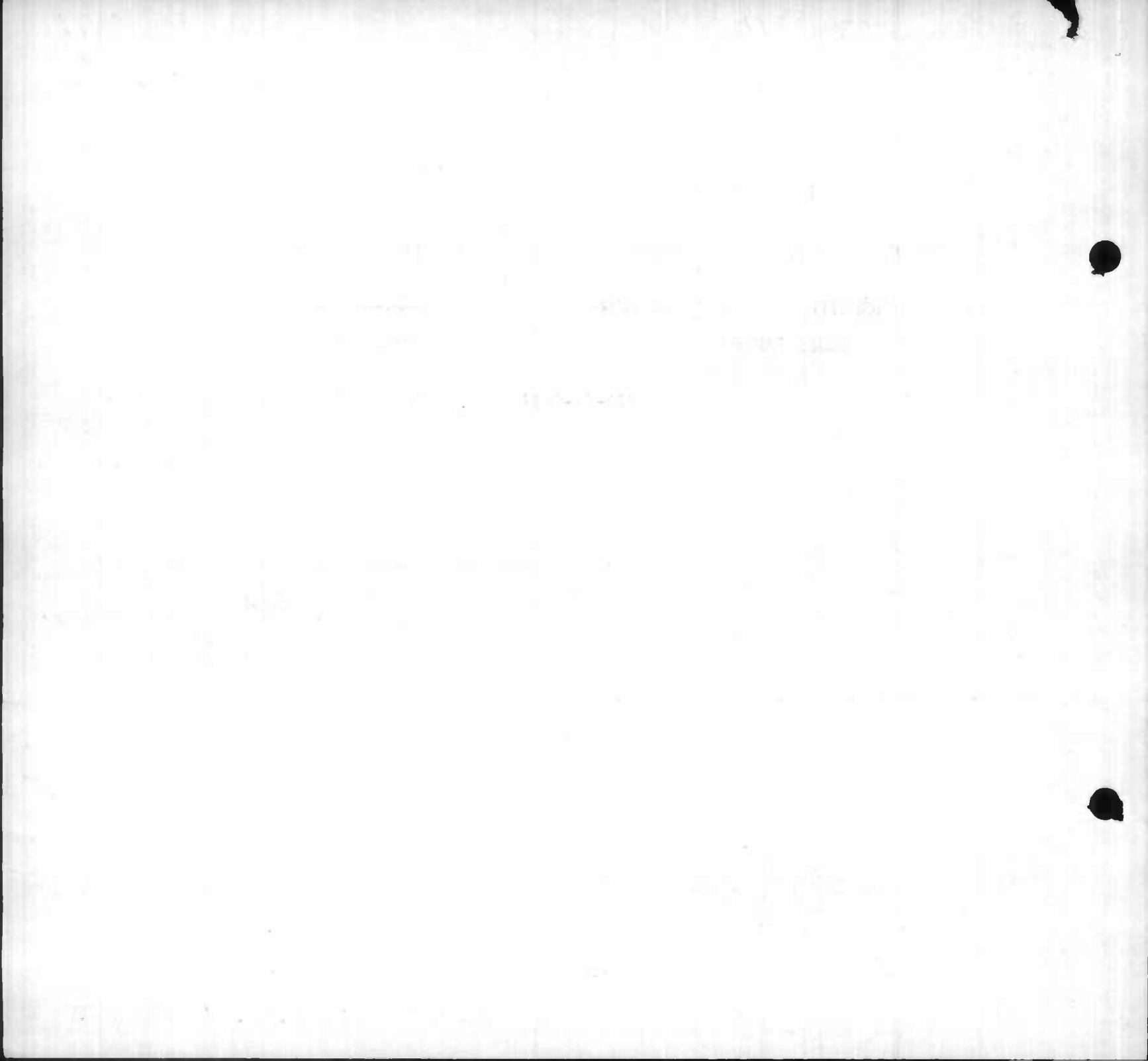
| | | | | | |
|---|-------------------------|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) Beatrice P. Weissfeld | | | 2. DATE AND HOUR PRONOUNCED DEAD Jan. 30, 1965 2:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-01 D. STREET ADDRESS (If rural, give location) 2601 Madison Avenue | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 15, 1913 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jacob H. Pleet | | | 14. MOTHER'S MAIDEN NAME Late Dora Miller | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Benjamin L. Weissfeld 2601 Madison Avenue | | |

| | | | | | | |
|-----------------------|--|--|--|---|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH E904.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) (A) Nephrosis and multiple pulmonary emboli ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Fracture of right hip OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) Bronchopneumonia | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| | 19A. DATE OF OPERATION 3 Jan. 8, 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture of hip | | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) n hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Lutheran Hospital 16-06 | |
| | 21D. TIME OF INJURY (APPROX.) Jan. 7, 1965 12:35P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell and broke hip | |
| | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| | ACTUAL SIGNATURE EXAMINER'S NAME (Type) John E. Adams, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED Jan. 30, 1965 | |
| | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE Jan. 31, 1965 | 23C. NAME of CEMETERY or CREMATORY Shaarei Zion | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| | 24A. DATE REC'D BY HEALTH DEPT. N820, FEB 2 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc. 6000 Reist. Rd. #15 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

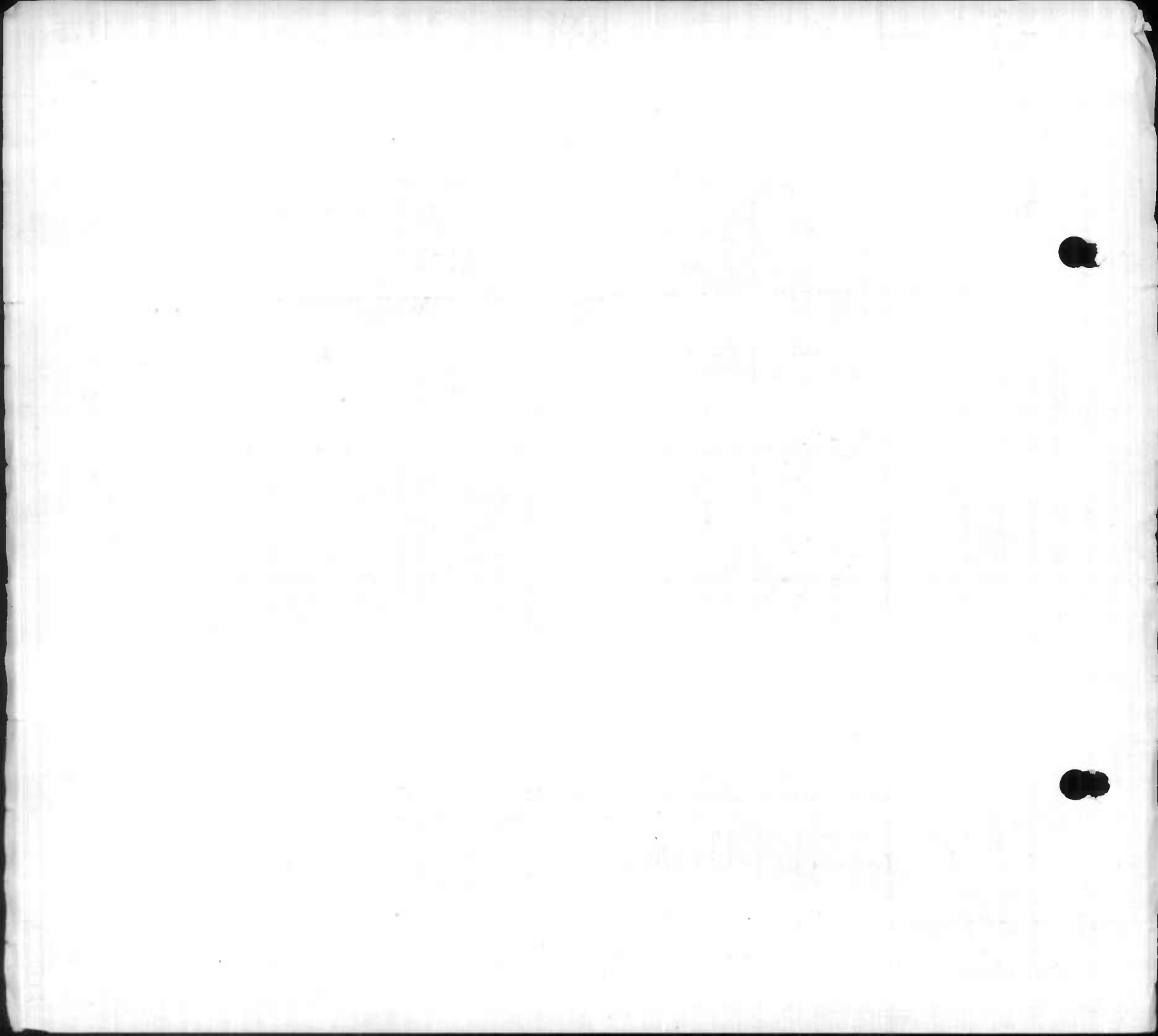
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|------------------|--|--|--|--|
| BIRTH NO. 65 1177 | | CERTIFICATE OF DEATH | | 65 1177 | |
| 1. NAME OF DECEASED (Type or Print) KATE FARBER | | | 2. DATE AND HOUR OF DEATH January 29, 1965 10 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5451 PARK HEIGHTS AVENUE | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5451 PARK HEIGHTS AVENUE | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 8/25/1890 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME MOSES FARBER | | |
| 14. MOTHER'S MAIDEN NAME MARY ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 215-48-0681 | | | 17. INFORMANT MR. VALE GORDON 227 CHANCERY ROAD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebro-vascular accident (B) arterio-sclerosis (C) hypothyroidism INTERVAL BETWEEN ONSET AND DEATH Sudden years. 20 yrs. 20 years. | | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Papets disease of skull | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 52 to Jan 29 1965, that (I) (we) last saw the deceased alive on Jan 28 1965 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph C. Matchar M.D. | | | 23B. DATE SIGNED January 31, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH C. MATCHAR M.D. | | | 23D. ADDRESS 6821 REISTERSTOWN RD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/2/65 | | 24C. NAME of CEMETERY or CREMATORY BETH VEHUDA ANSHE KURLAND | |
| 24D. LOCATION BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber M.D. | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|------------------|--|------------------------------|--|---|
| BIRTH NO. 65 1178 | | CERTIFICATE OF DEATH | | 65 1178 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mrs. Edna Glenn | | 2. DATE AND HOUR OF DEATH 1-29-65 2 30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5505 Daybreak Terrace | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4-2-1895 | 9. AGE (In years last birthday) 69 | 10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Adam Ditschler | | 14. MOTHER'S MAIDEN NAME Mary Vogelsang | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-05-7510D | | 17. INFORMANT Mr William E. Glenn 173 Hampshire Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinomatosis (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH - | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-13-1965 to 1-29-1965, that (I) (we) last saw the deceased alive on 1-29-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald G. Deinlein | | | | 23B. DATE SIGNED 1-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) Donald A. Deinlein | | 23D. ADDRESS 301 St. Paul Place 2 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-1965 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION Baltimore Co. | | 24E. (City, town, or county) (State) Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Tassan Funeral Home of Conti | |
| 25D. ADDRESS | | | | | |



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65 1179

BALTIMORE CITY HEALTH DEPARTMENT

65 1179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

W

George Sauers

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 30, 1965

5:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1900 Wilhelm Avenue

6

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-23-1900

9. AGE (In years
last birth day)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Selfemployed

10B. KIND OF BUSINESS OR INDUSTRY

Real Estate

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Sauers

14. MOTHER'S MAIDEN NAME

Mary Jane Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Lillian E. Sauers 1900 Wilhelm Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 31, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-2-1965

23C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION (City, town, or county)

Baltimore Co.

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Road

ADDRESS

VALUABLE
PROPERTY
PROTECTED
BY
CIVIL
SERVICE

W. 4/0

65 1180

BALTIMORE CITY HEALTH DEPARTMENT

65 1180

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHRISTIAN G. WOLF

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 29, 1965

6:00P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

438 N. Clinton Street 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-31-1889

9. AGE (in years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret. Breweryworker

10B. KIND OF BUSINESS OR INDUSTRY

National Brewrey

11. BIRTHPLACE (State or foreign country)

Baltimore County Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George M. Wolf

14. MOTHER'S MAIDEN NAME

Fredericka Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-01-4771

17. INFORMANT

Mrs Elizabeth M. Wolf 438 N. Clinton Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 30, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-2-1965

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

Baltimore Co.

(City, town, or county)

(State)

Md. ✓

24A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Road 36

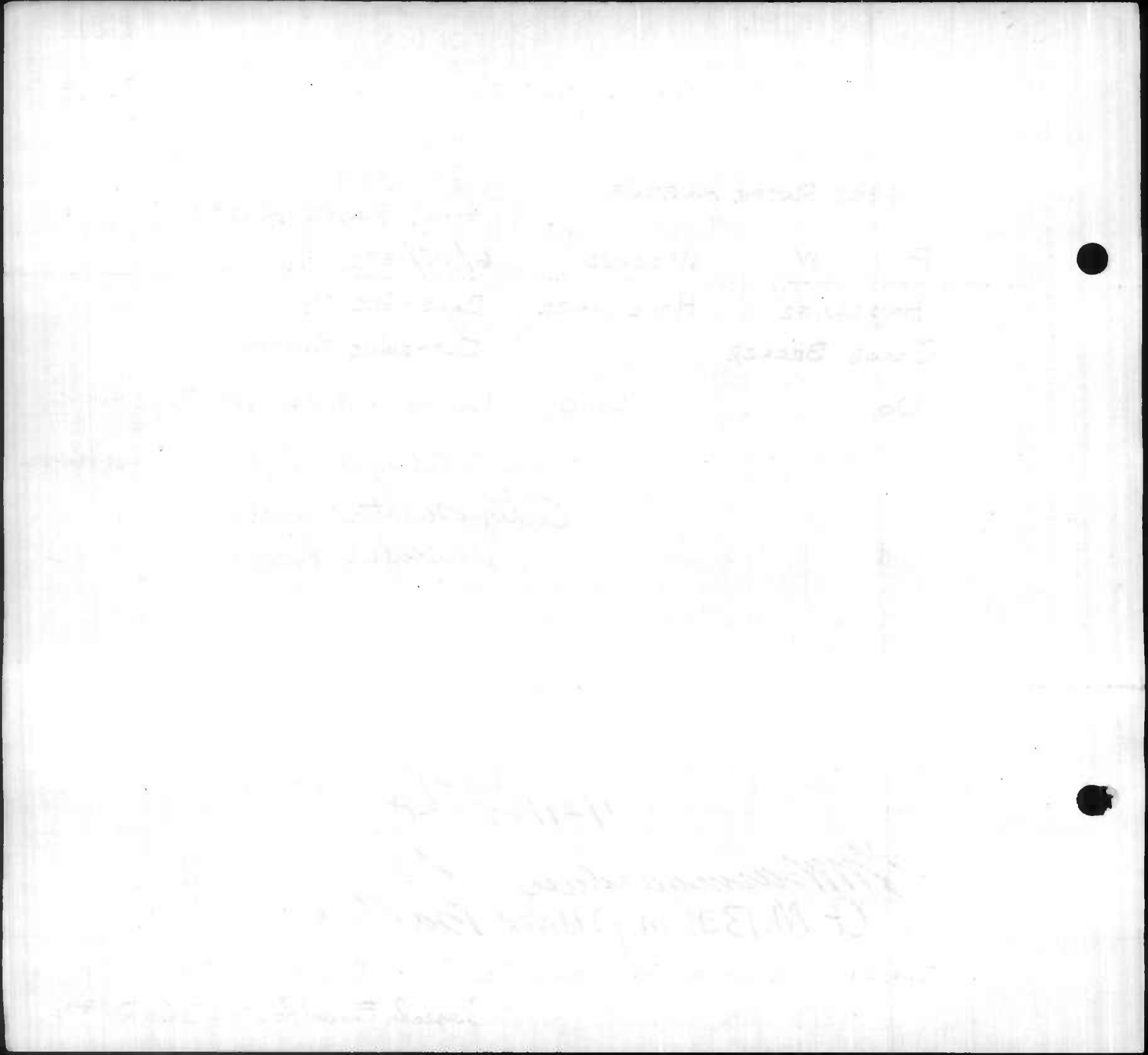
ADDRESS

WALLLEY FORDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

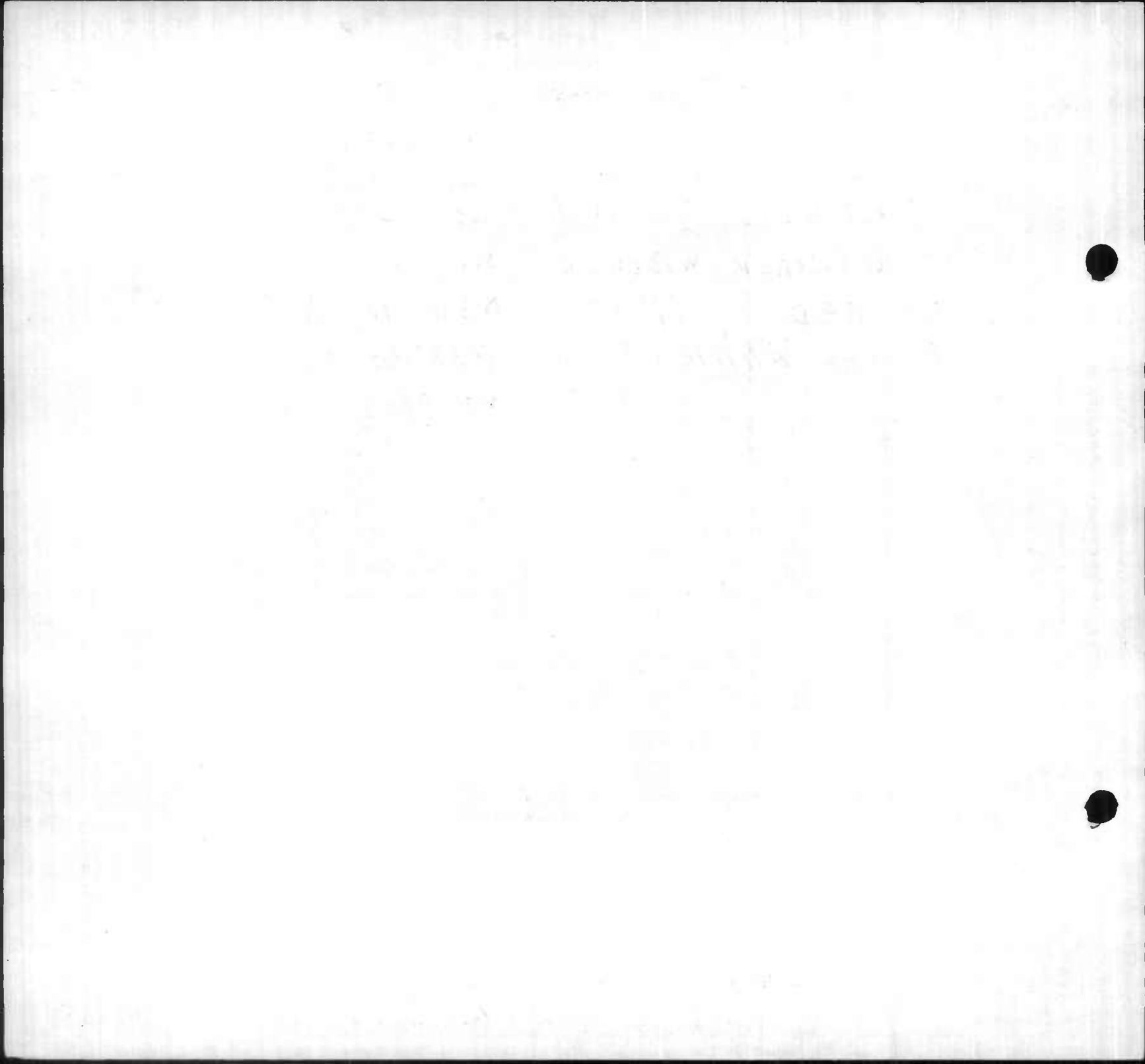
| | | | | | |
|---|--------------|---|---|--|---|
| 65 1181 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1181 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | ELIZABETH BARTENFELDER | |
| 2. DATE AND HOUR OF DEATH | | 1-30-1965 2 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | MD 26-01 | | | |
| 4423 RASPE AVENUE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 4423 RASPE AVE #6 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6/15/1873 | 9. AGE (In years last birthday) 91 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE |
| | | 10B. KIND OF BUSINESS OR INDUSTRY HOMEMAKER | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JACOB BECKER | | | 14. MOTHER'S MAIDEN NAME CATHERINE SNYDER. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS MRS ANNA NENEC. 4423 RASPE AVE 6. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH (A) DUE TO Coronary occlusion (B) DUE TO Arteriosclerosis Cardio (C) Vascular disease | | INTERVAL BETWEEN ONSET AND DEATH Sudden 3 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1 1964 to 1/29 1965. that (I) (we) last saw the deceased alive on 1/29/65 2 A and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. Baumgardner | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) G. M. Baumgardner | | | | 23D. ADDRESS Balto 6 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-2-1965 | | 24C. NAME OF CEMETERY or CREMATORY PARKWOOD Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Lassaly Funeral Home 7401 Belair Rd. #36. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1182 | |
|--|--------------------|---|--|--|---|---|--|
| BIRTH NO. 65 1182 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lucy Whitten Burg | | 2. DATE AND HOUR OF DEATH 1-30-1965 10:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-32 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 402 SEAGULL AVE BALTIMORE 25, Md. | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #25, Md. | | D. STREET ADDRESS (If rural, give location) 402 SEAGULL AVE | |
| 5. SEX FEMALE | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH June-13-1 | 9. AGE (In years last birthday) 66 63 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | |
| 11. BIRTHPLACE (State or foreign country) NEWTON, N.C. | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | 13. FATHER'S NAME DALLAS WHITTEN BURG | |
| 14. MOTHER'S MAIDEN NAME MARTHA WHITTEN BURG | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT MRS. FRANCIS TUTTLE | | ADDRESS 402 SEAGULL | | 18. 420.0-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Acute Nephritis (B) Arteriosclerotic Heart (C) Hypertensive Heart | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 days | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Thrombosis | | 19A. DATE OF OPERATION | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 1963 to Jan 30, 1965, that (I) (we) last saw the deceased alive on Jan 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE JERRY L. LUCKY | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Jan 30, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. 629 Swale 21225 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A.A. County Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR R. M. Mott & Dyett | | ADDRESS 916 Penna Ave | |



42-62-03-N1

FUNERAL DIRECTOR: IMPORTANT

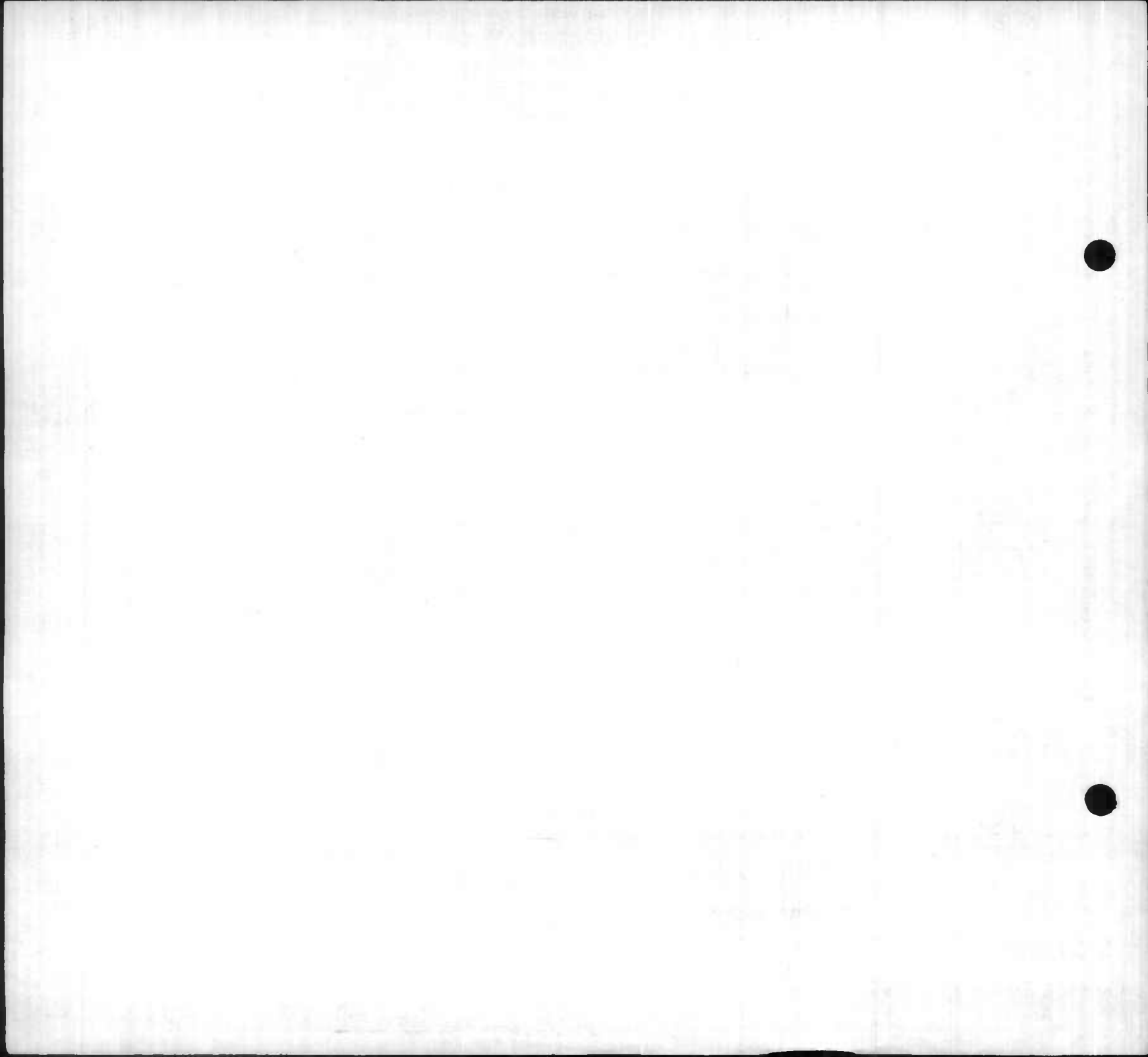
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1183 | |
|---|---------|--|------------------|--|------------------------------|
| BIRTH NO. 65 1183 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lustrena Beckwith | | | |
| 2. DATE AND HOUR OF DEATH | | 1-31-65 2:45 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | Maryland, Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Rural | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 803 I Street #21219 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| Female | Negro | Widowed | 5-5-87 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| William I. Johnson | | Laura Bonnett | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 214-10-0139B | | RECORDS: B.C.H. 4940 Eastern Avenue #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) Myocardial Infarction | | 2 Weeks | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-16 19 65 to 1-31 19 65, that (I) (we) last saw the deceased alive on 1-31- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. Robert Cooke | | | | 1-31-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. Robert Cooke | | M.D. 4940 Eastern Avenue #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-4-65 | | Mount Calvary Cemetery | |
| | | | | A.A. County Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 2 1965 | | G. E. E. F. E. M. A. | | The Morton and Dyett 916 Penna Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

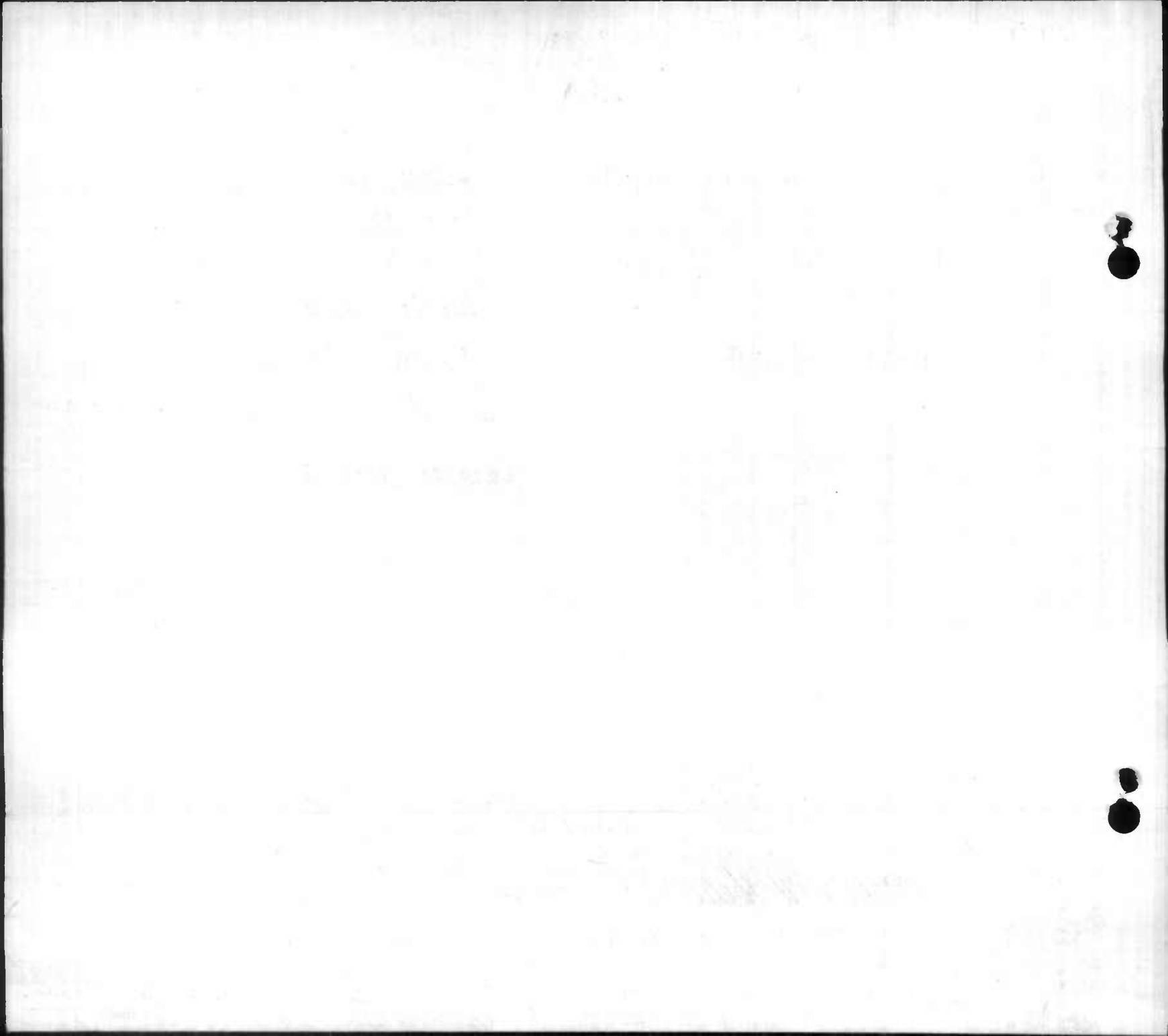
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|--|--|---------------------------------------|--|
| 65 1184 | | CERTIFICATE OF DEATH | | 65 1184 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| ALVIN SYLVESTER PAYNE | | | 1/29/65 1:00 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| UNIVERSITY HOSPITAL | | | MD. 15-01 | | |
| 5. SEX M | | | 6. RACE N. | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | | |
| SINGLE | | | 7/12/05 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| PAINTER | | | VA. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WILLIAM PAYNE | | | IDA BLACKWELL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| | | | 30-47-88 | | WAITRESS HOLLEY 2455 DEVID HILL |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) INTRACEREBRAL HEMORRHAGE | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 2 | | | | | YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from JAN 28 1965 to JAN 29 1965, that (I) (we) lost saw the deceased alive on JAN 29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ruth Luddy | | | 23B. DATE SIGNED 1/29/65 | | |
| 23C. PHYSICIAN'S NAME (Type) RUTH LUDDY | | | 23D. ADDRESS UNIVERSITY HOSP. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| Burial | | 2-2-65 | Mt. Auburn Cemetery | | Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Morton Dyett | |
| | | | | ADDRESS 916 Penna Ave | |



FUNERAL DIRECTOR: IMPORTANT

certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

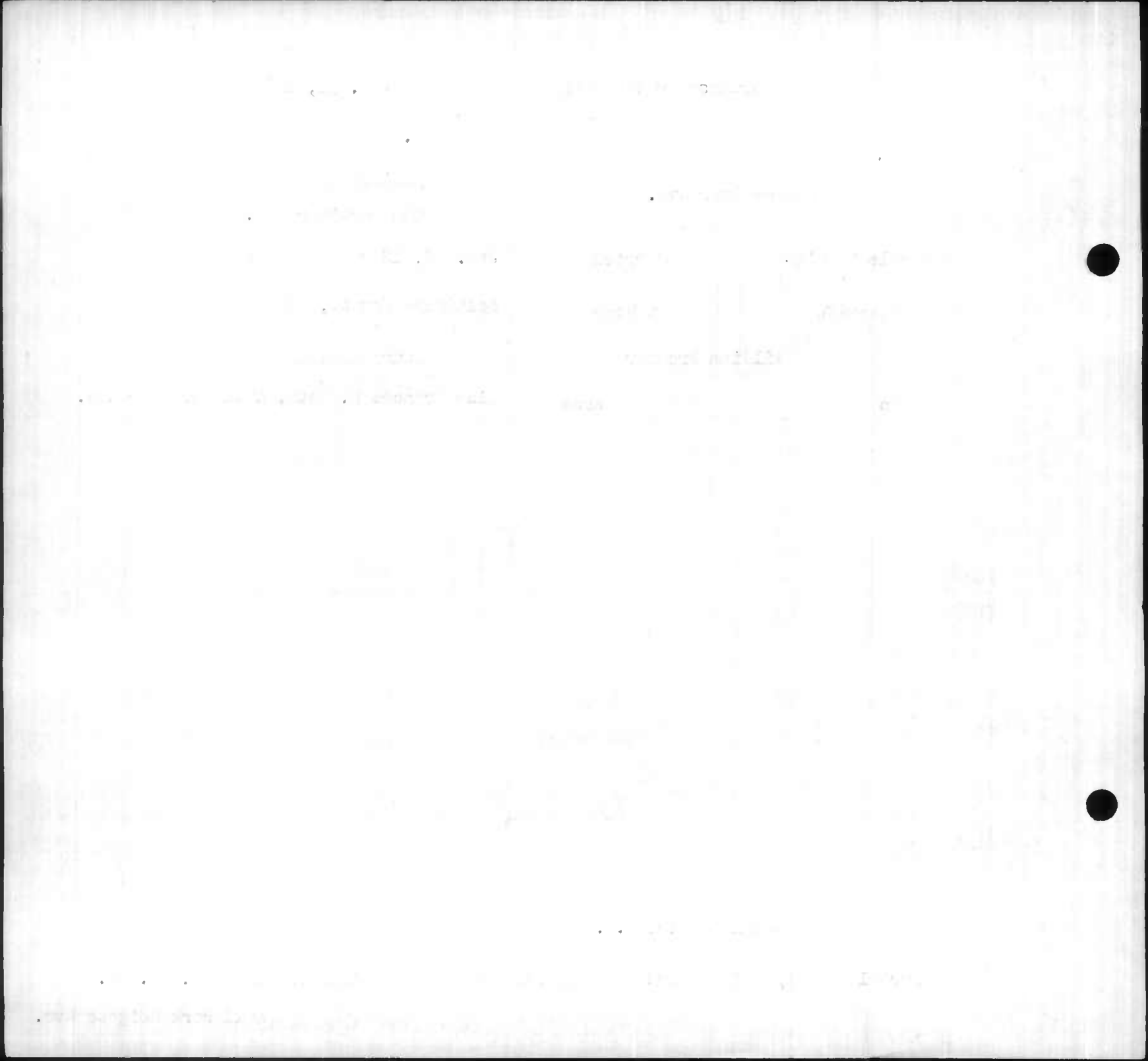
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|---------------------|--|---|--|--|--|--|--|--|--|
| 64-25820 65 1185 CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1185 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Theresa Bialek</i> | | | | | | 2. DATE AND HOUR OF DEATH <i>9:21 AM 11/29/65</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i> | | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Chase 5300</i> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <i>Box 101</i> | | | | | |
| 5. SEX <i>F</i> | | 6. RACE <i>W</i> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>child</i> | | 8. DATE OF BIRTH <i>9-21-64</i> | | 9. AGE (In years last birthday) | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i> | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Robert Bialek</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Isabel Shipa</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Parents</i> | | | | ADDRESS <i>same as above</i> | |
| 18. <i>433.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | | |
| CAUSE OF DEATH (A) <i>Cardiac Arrest</i> DUE TO | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> | | | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>1</i> | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/27</i> 19 <i>65</i> to <i>11/29</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>11/29/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Richard H. Heller</i> | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>11/29/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Richard H. Heller</i> | | | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1186 | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 65 1186 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Hortense Gussie Roth | | 2. DATE AND HOUR OF DEATH Jan. 31, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 4002 Mortimer Ave. | | A. STATE Md. B. COUNTY 27-19 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 4002 Mortimer Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 28, 1889 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Baltimore County, Maryland | |
| 13. FATHER'S NAME William Bremker | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. none | | |
| 17. INFORMANT Miss Frances B. Roth, 4002 Mortimer Ave. | | | ADDRESS | | |
| 18. 422.1 I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Chronic Hypertension Myocardial Infarction | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 15, 1965 to January 31, 1965 , that (I) (we) last saw the deceased alive on January 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. Rudner M.D. | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/31/65 |
| 23C. PHYSICIAN'S NAME (Type) Cecil Rudner, M.D. | | | 23D. ADDRESS 6821 Reisterstown Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/65 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Falek, M.D. | | 25C. FUNERAL DIRECTOR B. Vernon Gannon | |
| | | | | ADDRESS 4611 Park Heights Ave. | |



G. 600

65 1187

BALTIMORE CITY HEALTH DEPARTMENT

65 1187

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|--|---------------------------|---|---------------------------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) ELLA GRAY | | | | 2. DATE AND HOUR PRONOUNCED DEAD 1/29/65 11:45 a. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3801 Bonner Rd. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY 15-38 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Maryland D. STREET ADDRESS (If rural, give location) 3801 Bonner Rd. | | | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 12-10-1889 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME James White | | | | 14. MOTHER'S MAIDEN NAME Ella White | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Clarice Gibbons 3801 Bonner Rd. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) W.U. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 23B. DATE Feb. 1, 1965 | | 23C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 24B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 24C. FUNERAL DIRECTOR Williams Funeral Home | | 24D. LOCATION (City, town, or county) (State) Balt. Md. | |

WALLIS & GORDON

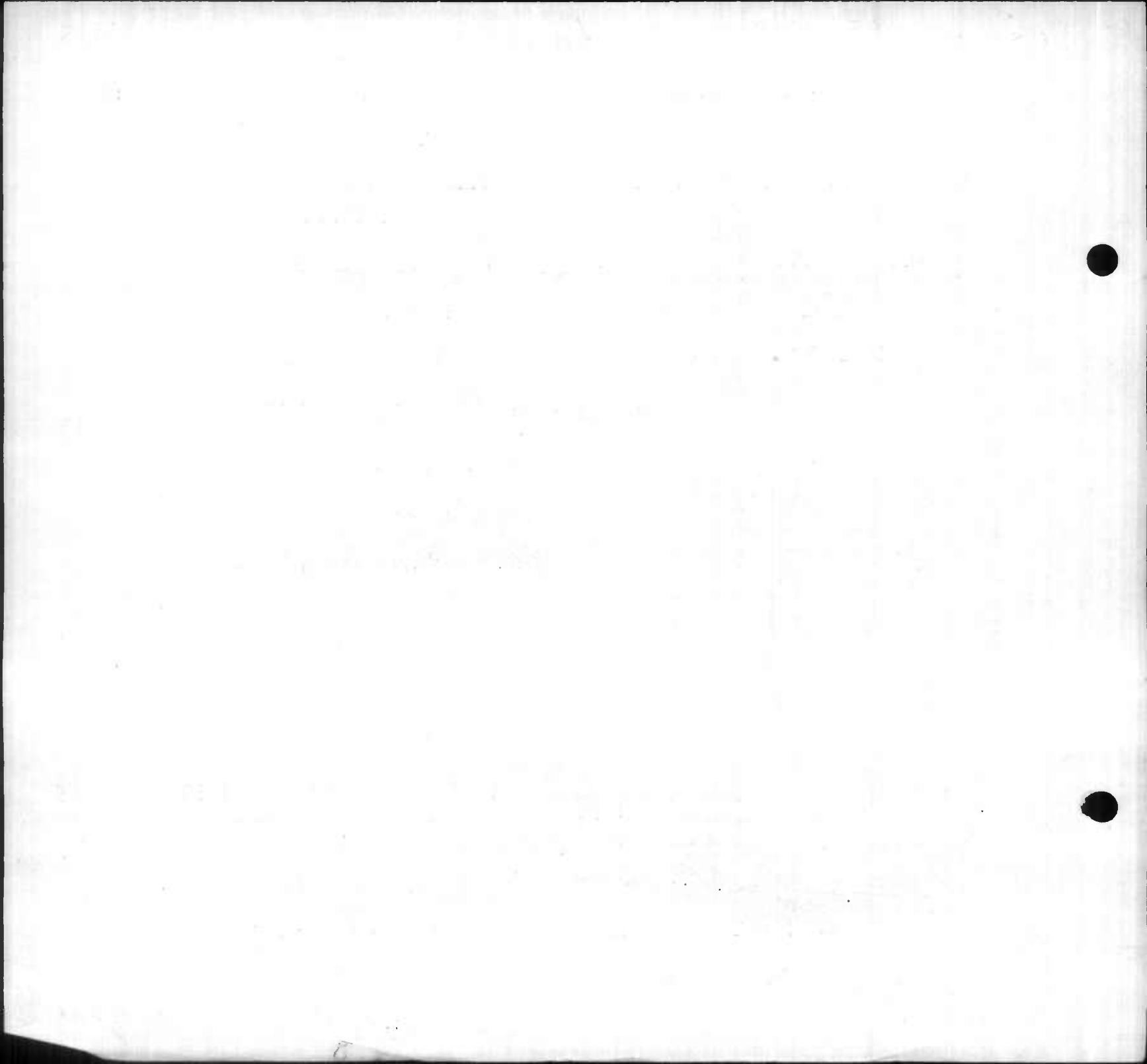
DEPT. OF AGRICULTURE

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

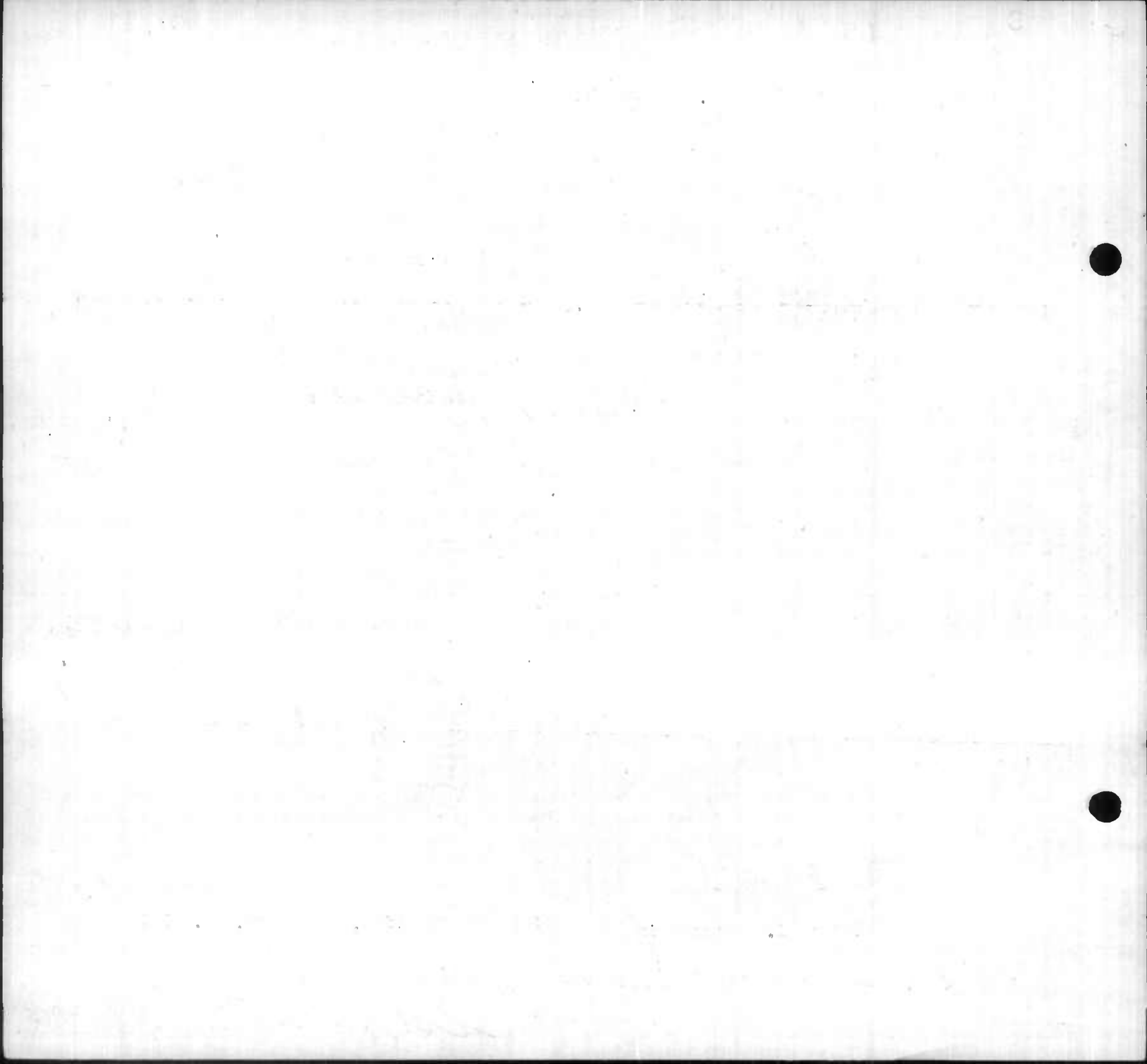
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------|--|--|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1188 | | | | |
| BIRTH NO. 65 1188 | | | | | 2. DATE AND HOUR OF DEATH 1 30 65 9:30A M. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ROBERT F STEFFEN | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | | A. STATE MARYLAND | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELICOTT CITY | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1007 FREDERICK RD | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 10 28 99 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAIRY WORK | | 10B. KIND OF BUSINESS OR INDUSTRY DAIRY | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? GERMANY | | | |
| 13. FATHER'S NAME KARL STEFFEN | | | | | 14. MOTHER'S MAIDEN NAME MARTHA FENNER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. 217 384 388 | | 17. INFORMANT ADDRESS ST AGNES HOSP RECORDS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) Uterine Cancer | | | | |
| | | | | | (B) Septicemia | | | | |
| 19. ANTECEDENT CAUSES | | | | | (C) Metastatic @ lower lobe of R Lung | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1 29 1965 to 1 30 1965, that (I) (we) last saw the deceased alive on 1 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Miguel A Heredia M.D. | | | | | 23B. DATE SIGNED 1-30-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) MIGUEL A HEREDIA | | | | | 23D. ADDRESS ST AGNES HOSP | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/26/65 | | 24C. NAME OF CEMETERY OR CREMATORY GOOD SHEPHERD | | 24D. LOCATION (City, town, or county) HOWARD CO MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | | 25C. FUNERAL DIRECTOR E. S. MACNABB | | ADDRESS 301 FREDERICK RD 21228 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

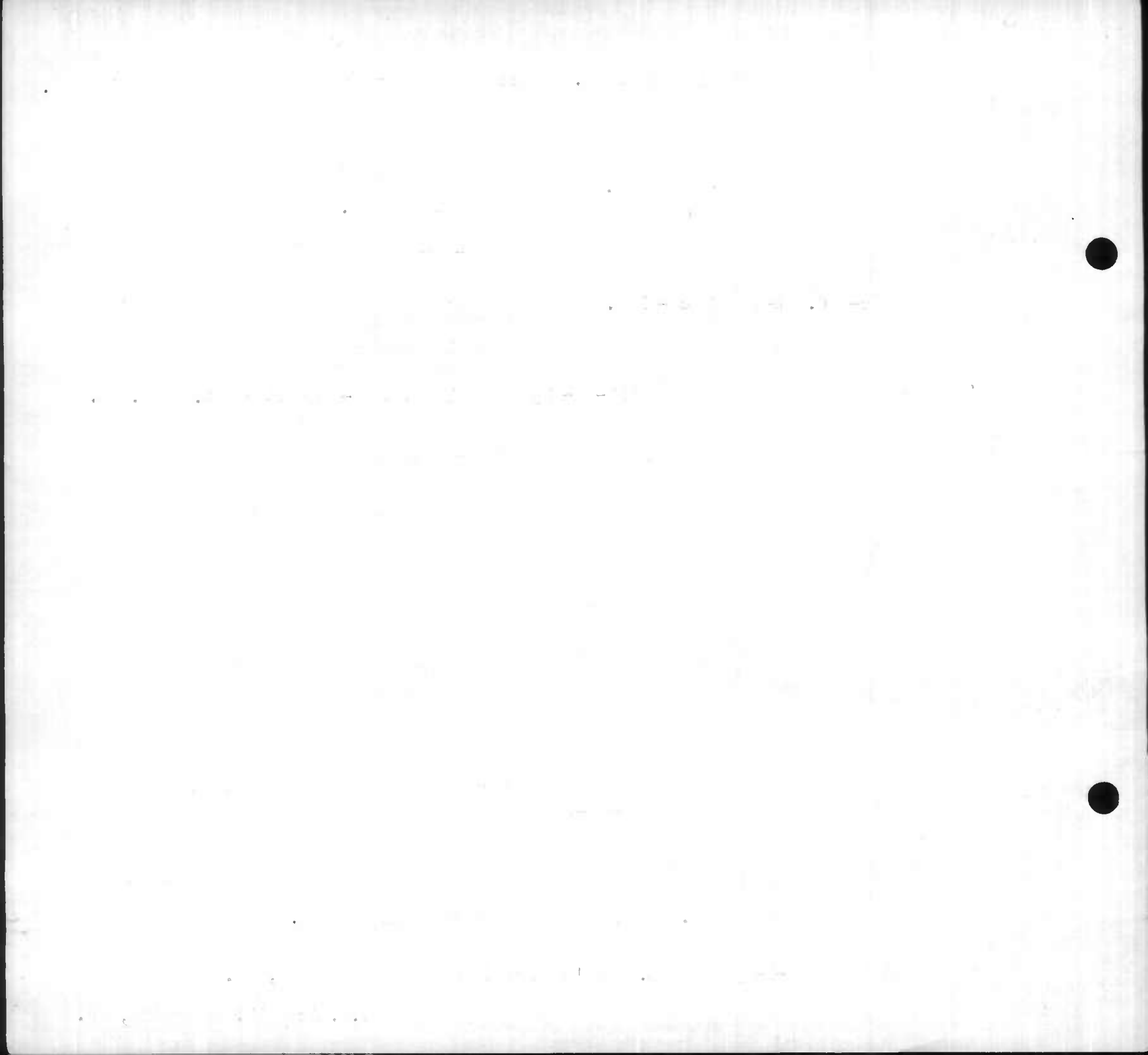
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1189 | |
|--|---------------------|---|--|--|---|
| BIRTH NO. 65 1189 | | | | CERTIFICATE OF DEATH X | |
| 1. NAME OF DECEASED (Type or Print) JAMES GREEN | | 2. DATE AND HOUR OF DEATH JAN. 26, 1965 5:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8 HARWOOD - P.O. 52-00 D. STREET ADDRESS (If rural, give location) RT. 2 Box 108 | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH JULY 10, 1898 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME JAMES GREEN | | 14. MOTHER'S MAIDEN NAME SELMA ? | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 332X + 260X | | CAUSE OF DEATH (A) CEREBRAL THROMBOSIS (B) ARTERIOSCLEROSIS (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 months unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | DIABETES MELLITUS | | Several yrs. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ? | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-16 1964 to 1-26 1965 , that (I) (we) last saw the deceased alive on 1-26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Irving L. Cooperstein | | | | 23B. DATE SIGNED JAN 26, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein | | | | 23D. ADDRESS Argonne Drive, Baltimore, Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-29-65 | | 24C. NAME OF CEMETERY OR CREMATORY Chews Chapel | |
| 24D. LOCATION (City, town, or county) (State) A.A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Richmond | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

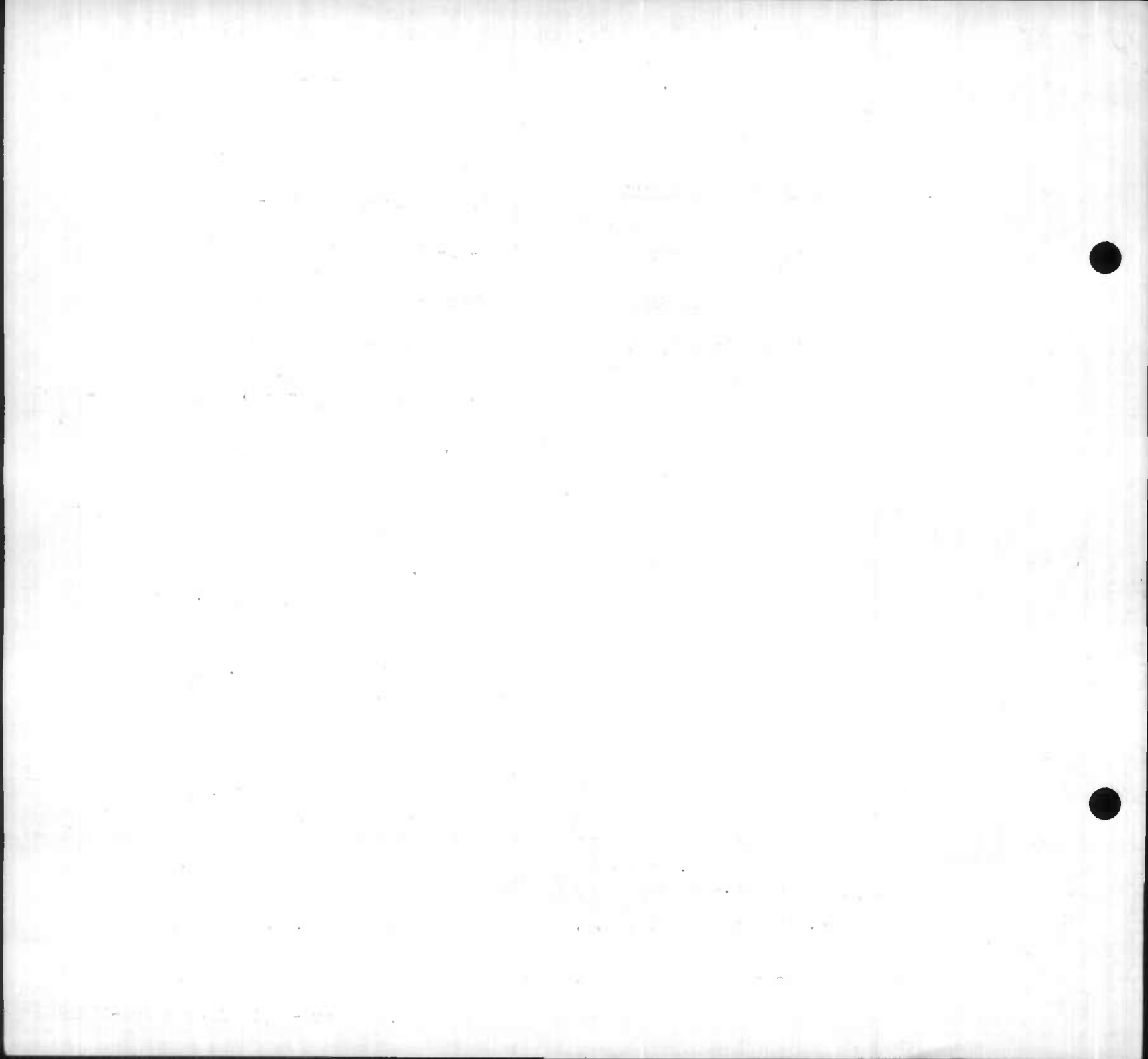
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | 65 1190 | |
|--|------------------|---|--|--|--|--|--|---|--|-------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1190 | |
| BIRTH NO. 65 1190 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Anna Harris middle N. Rebecca | | | | | | 2. DATE AND HOUR OF DEATH 1-28-65 | | 2:00 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland | | | | | | | | | |
| Provident Hospital 1514 Division St. Baltimore, Maryland 21217 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis | | | | | | | | | |
| | | D. STREET ADDRESS (If rural, give location) 47 Fleet St. | | | | | | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 12-20-05 | | 9. AGE (In years last birthday) 59 | | 10. Under 1 Yr. Months Days | | 10. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic- Md. State Office-Bldg. | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Offer | | | | 14. MOTHER'S MAIDEN NAME Sadie Snowden | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 213-36-0156 | | 17. INFORMANT Naomi Pettaway-9 Rosemary St. Anna. Md. | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 181.0 I Cardio-Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer of Urinary Bladder Marked Anemia | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-6-65 19 to 1-28-65 19, that (I) (we) last saw the deceased alive on 1-28-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Delfine P. David | | | | 23B. DATE SIGNED 1-28-65 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Delfine P. David | | | | 23D. ADDRESS 1514 Division St. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-65 | | 24C. NAME of CEMETERY or CREMATORY St. Mary's Catholic | | 24D. LOCATION (City, town, or county) (State) Annapolis, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR R. E. Fairley | | 25C. FUNERAL DIRECTOR C. E. Hicks | | ADDRESS 111 Annapolis, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

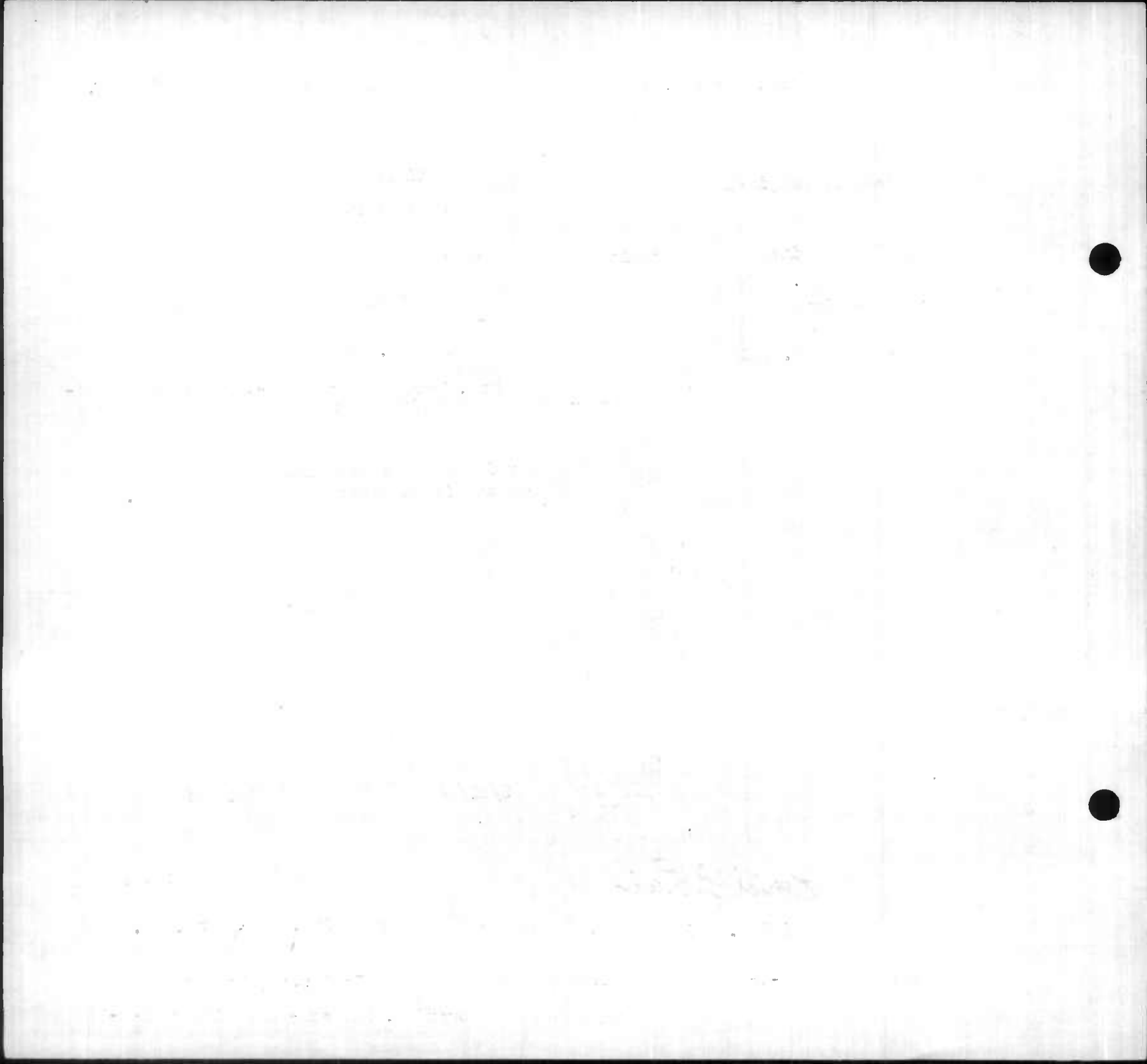
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | Registered No. 65 1191 |
|---|---|---|--|---|---|---|
| 1. NAME OF DECEASED (Type or Print) Annie E. Odensos | | | 2. DATE AND HOUR OF DEATH 1-30-65 @ 8:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SAINT AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3508 Georgetown Road - 21227 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2-25-87 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 13. FATHER'S NAME George Arnold, Sr | | | 14. MOTHER'S MAIDEN NAME Elizabeth Winters | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sr. ADDRESS Mr. William Odensos-3508 Georgetown Rd-21227 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X + 260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Hypertensive C-V-D DUE TO (B) Essential Hypertension DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 15 yrs + | |
| | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity + Diabetes Mellitus | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 16 1952 to Jan. 30 1965, that (I) (we) last saw the deceased alive on January 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE C. Arthur Rossberg M.D. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 2/1/65 | | |
| 23C. PHYSICIAN'S NAME (Type) C. Arthur Rossberg, M.D. M.D. | | | | 23D. ADDRESS 2436 Washington Blvd. 21230 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1192 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 65 1192 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Helm, Naomi Irene | | | | 2. DATE AND HOUR OF DEATH 1/30/65 1:50 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 825 Stamford Road | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 5/23/1895 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser-Skirts | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Isaac White M. Helm | | | 14. MOTHER'S MAIDEN NAME Mary V. Brown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-07-6815 | | 17. INFORMANT ADDRESS Mrs. Marie Montgillion-1253 Haverhill Rd-29 Hospital Records | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Breast with Metastasis to Lungs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 yrs. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/21/64 19 to 1/30/65 19, that (I) (we) last saw the deceased alive on 1/30/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel G. Lai | | | | 23B. DATE SIGNED 1/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) Daniel G. Lai | | | | 23D. ADDRESS M.D. 2201 Argonne Drive, Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-2-65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1193 | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 65 1193 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Anna Snyder | | | |
| 2. DATE AND HOUR OF DEATH 1/31/65 5:50 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore County | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Edgemere 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 7609 Northpoint Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 12/2/87 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Langle | | 14. MOTHER'S MAIDEN NAME Wilhelmena ?? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Daughter, Pauline Ballerstadt, #4, a, b c | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovascular Dis. (B) DUE TO Bilat. pneumonia (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 day 30 yr 1 day | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/30/65 19 65 to 1/31 19 65 , that (I) (we) last saw the deceased alive on 1/31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Willis C. Maddrey | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) Willis C. Maddrey | | 23D. ADDRESS Johns Hopkins Balt., Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-1965 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION (City, town, or county) (State) Trumps Mill Rd. Bal. Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR JOHN J. DUDA, 7922 Wise Ave. 22, Md. | |

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MEDICAL EXAMINER'S CASE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X | | | | | | | | | | | |
|--|---------------------|---|--|--|--|---|--|---|---|--|--|
| BIRTH NO. 65 1194 | | Registered No. 65 1194 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) AMOS Z. CHEEK | | | | | | 2. DATE AND HOUR OF DEATH Jan 31, 1965 7:30 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. Hospital | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 19 53-00 | | | | | |
| D. STREET ADDRESS (If rural, give location) 3009 Salisbury Ave. | | | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 4/2/96 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Electrician | | | | 10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL CO. | | 11. BIRTHPLACE (State or foreign country) North Carolina | | | 12. CITIZEN OF WHAT COUNTRY? U.S. A | | |
| 13. FATHER'S NAME Sherman Cheek | | | | | | 14. MOTHER'S MAIDEN NAME Jeannette BYRD | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 218-072831 | | 17. INFORMANT WIFE (KATHRINE) | | | ADDRESS Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 241 X Y E 903.0 PULMONARY EMPHYSEMA (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic asthma | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fracture of @ Femur | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? 3009 Salisbury Ave | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-24/65- 8AM | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell on L | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 24 1965 to Jan 31 1965 , that (I) (we) last saw the deceased alive on Jan 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Dr. George J. St. | | | | | | 23B. DATE SIGNED 1-31-65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. George J. St. | | | | | | 23D. ADDRESS Md. General Hosp. Balto. Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-1965 | | 24C. NAME OF CEMETERY OR CREMATORY Enders Cemetery | | 24D. LOCATION (City, town, or county) (State) Jackson Township, Dauphin Co. Pa | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. 1/31/65 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR JOHN J. DUDA | | | | ADDRESS 7922 Wise Ave. 21222, Md. | | | |

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Handwritten text in the lower middle section, possibly a subtitle or description.

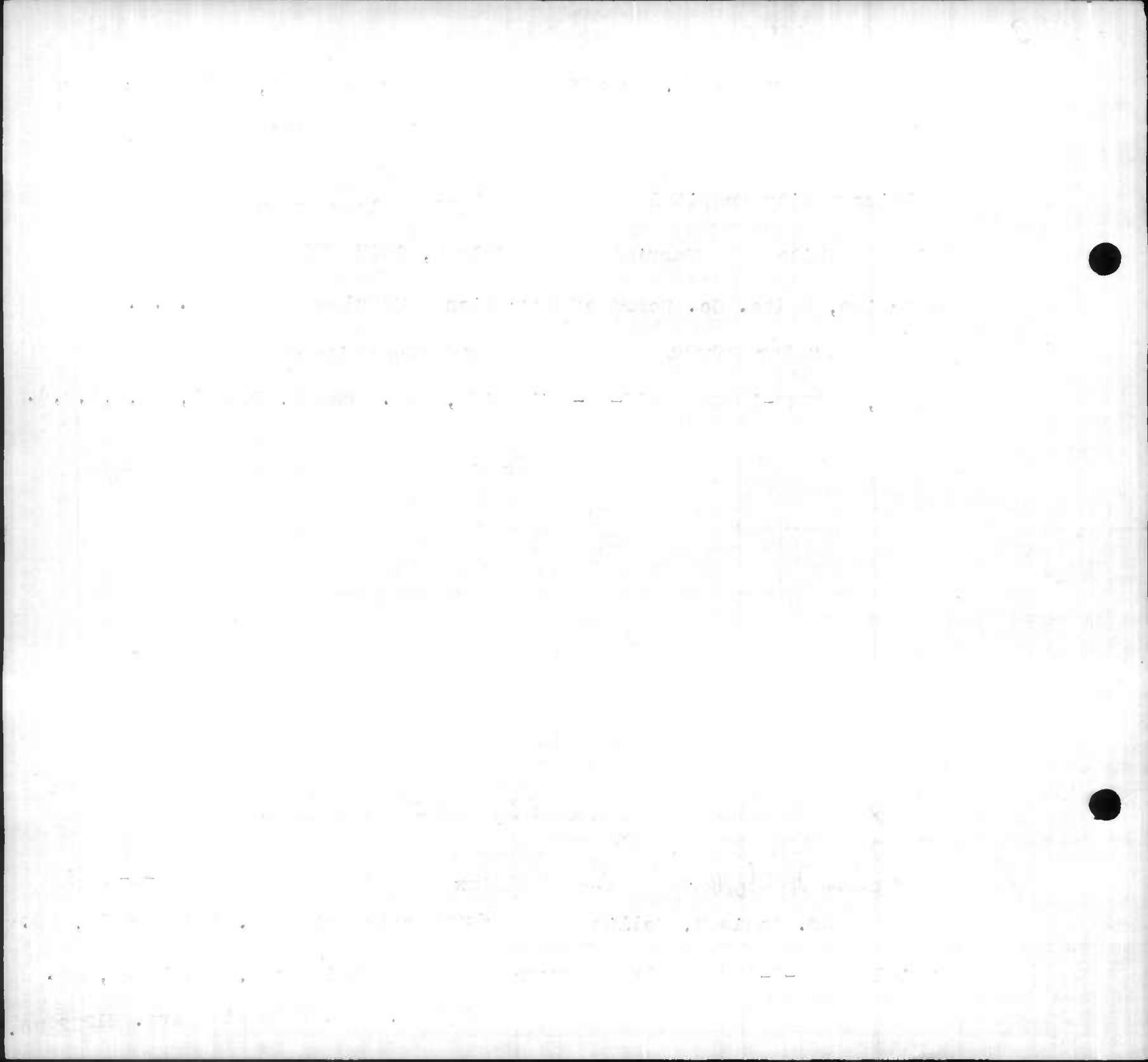
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Handwritten text in the bottom right section, possibly a signature or date.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|--|--|---|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1195 | | | | |
| BIRTH NO. 65 1195 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) Gustav F. Hubert | | | | | 2. DATE AND HOUR OF DEATH January 31, 1965 9:25 a.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital | | | | | A. STATE Maryland B. COUNTY Baltimore | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgemere | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 2914 Delmar Avenue | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH July 3, 1907 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian, Balto. Co. Board of Education | | | 10B. KIND OF BUSINESS OR INDUSTRY Co. Board of Education | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gustav Hubert | | | | | 14. MOTHER'S MAIDEN NAME Johanna Walters | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Army, 1929-1930 | | | 16. SOCIAL SECURITY NO. 215-30-0272 | | 17. INFORMANT ADDRESS Wife, Mrs. Anna A. Hubert, #4, a, b, c, d. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary thrombosis | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | | |
| | | | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 1951 to Jan. 31 - 1965 , that (I) (X) last saw the deceased alive on Jan. 26 - 1965 and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Louis N. Tollin M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED Feb-1-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Louis N. Tollin | | | | | 23D. ADDRESS 6908 North Point Rd. Edgemere 19, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-1965 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer | | | 24D. LOCATION (City, town, or county) (State) Belair Road, Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA 7922 Wise Ave. 21222 Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1196 | |
|---|---------------------|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1196 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Marjorie Widmeyer</i> | | | 2. DATE AND HOUR OF DEATH <i>11/29/65 8-25 A M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Washington</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>HAGERSTOWN</i> D. STREET ADDRESS (If rural, give location) <i>731 VIRGINIA AVE</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>8-9-05</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Dress Shop</i> | | 11. BIRTHPLACE (State or foreign country) <i>Berkley Springs, W. Va.</i> | |
| 13. FATHER'S NAME <i>EDWARD A. RIDER</i> | | | 14. MOTHER'S MAIDEN NAME <i>SARAH E. PAYNE</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>577-16-7387</i> | | 17. INFORMANT <i>Mrs. Marjorie Rider Kildow</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>slow negative Septicemia</i> <i>Pneumonia</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i> <i>48 hours</i> | | |
| 19A. DATE OF OPERATION <i>11/19/65</i> | | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intestinal obstruction</i> | | | | | |
| 20A. AUTOPSY? (Yes or No) <i>YES</i> | | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/6</i> 19 <i>65</i> to <i>11/29</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>11/29</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Carl Bredenberg</i> | | | | 23B. DATE SIGNED <i>11/29/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>CARL BREDEBERG</i> | | | | 23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/2/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Rest Haven n Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Hagerstown Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Rest Haven Funeral Chapel Hagerstown, Md.</i> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|------------------|--|--|--|------------------------------|
| BIRTH NO. 65 1197 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH X | | Registered No. 65 1197 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ELFREIDA M. HAAK</u> | | | | 1-28-65 8 35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| UNIVERSITY HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE, MARYLAND | |
| D. STREET ADDRESS (If rural, give location) | | 5238 WASENA AVE #25 | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| F | W | WIDOWED | 7-13-88 | 76 | NONE | MARYLAND | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| CASPER DENHARDT | | | | Elizabeth? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | | | Family - Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) PULMONARY EMBOLUS | | | |
| ANTECEDENT CAUSES | | | | (B) PELVIC THROMBOSIS | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) CARCINOMA CERVIX Stage II | | | |
| II | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 1/28/65 | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 1/25/65 | | | | CARCINOMA CERVIX | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12:10 to 1:28 1965, that (I) (we) last saw the deceased alive on 1/28/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Robert S. Coplan M.D. | | | | 1/28/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Robert S. Coplan M.D. | | | | 825 Park Ave Balto, MD | | | |
| 24A. BURIAL CERTIFICATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 13 | | 2/10/65 | | Glen Haven | | Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 2 1965 | | Robert E. Jenkins, M.D. | | McCall - 2536 | | PATAPSCO AVE. | |

Handwritten text, possibly a signature or name, located in the upper left quadrant of the page.

Handwritten text, possibly a date or a short phrase, located in the center of the page.

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R-163

65 1198

BALTIMORE CITY HEALTH DEPARTMENT

65 1198

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Roger Rafferty

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 29, 1965 8:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

211 W. Riverview Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

5/28/21

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ELEC.

10B. KIND OF BUSINESS OR INDUSTRY

MD. DRYDOCK

11. BIRTHPLACE (State or foreign country)

MASS.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

FRANK RAFFERTY

14. MOTHER'S MAIDEN NAME

IRENE CORTO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES WW 2

16. SOCIAL
SECURITY NO.

17. INFORMANT

FAMILY

ADDRESS

SAME

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) Consolidated bronchopneumonia,
DUE TO bilateral

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty Metamorphosis of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 30, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2/2/65

23C. NAME of CEMETERY or CREMATORY

BALTO. NATIONAL CEM

23D. LOCATION

BALTO. MD

24A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

McCULLY FUNERAL HOME 237 PATAPSCO AVE.

ADDRESS

WALL-LEWIS & CO. INC.

APPROPRIATE

APPROPRIATE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------------|--|---|--|---|
| BIRTH NO. 65 1199 | | CERTIFICATE OF DEATH | | Registered No. 65 1199 | |
| 1. NAME OF DECEASED (Type or Print) EMMA VANCE | | 2. DATE AND HOUR OF DEATH 1-29-65 3:25 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY AA | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3554 Helmsletter | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 52-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3554 Helmsletter | | | |
| 5. SEX F. | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S. | 8. DATE OF BIRTH 7-8-89 | 9. AGE (In years lost birthday) 75 | 10. CITIZEN OF WHAT COUNTRY PA. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME John Vance | | | 14. MOTHER'S MAIDEN NAME Eliza McKnight | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family - Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 154X I | | CAUSE OF DEATH (A) Carcinoma of lower bowel & rectum DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 3, 1963 to January 29, 1965 that (I) (we) last saw the deceased alive on January 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Deibel | | | | 23B. DATE SIGNED 1/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Harry Deibel | | 23D. ADDRESS M.D. 1226 S. Hanover Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (specify) B | 24B. DATE 2-1-65 | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Helmsletter - 737 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **65 1200**

BIRTH NO. **65 1200**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STEWART, BESSIE F.

2. DATE AND HOUR OF DEATH

Jan. 29, 1965, at 6:45

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

Balt

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

5300

D. STREET ADDRESS (If rural, give location)

PRESBYTERIAN HOME OF MD. TOWSON. 21204

5. SEX

FEMALE WHITE

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED

8. DATE OF BIRTH

1/12/83

9. AGE (In years
lost birthday)

82

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

AMERICAN

13. FATHER'S NAME

DAVID FISHACK

14. MOTHER'S MAIDEN NAME

ELIZABETH HORNER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

18. **420.1 OF E904.7**
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) **ACUTE MYOCARDIAL
INFARCTION**

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO
DISEASE OR CONDITION CAUSING IT.

Fracture of hip

19A. DATE OF OPERATION

JAN. 26, 1965

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

POOR FRACTURE HIP

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

PRESBYTERIAN HOME HOME

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
JAN 23 1965

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

FELL DOWN

22. I certify that (I) (this hospital) attended the deceased from **JAN 25** 19**65** to **JAN 29** 19**65**,
that (I) (we) last saw the deceased alive on **JAN 29** 19**65** and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Chi Tsung. Su

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

JAN. 29. 65

23C. PHYSICIAN'S
NAME (Type)

GEORGE EATON

M.D.

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2-2-65

24C. NAME OF CEMETERY or CREMATORY

LOUDON PARK

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

NE20. OF FEB 2 1965

25B. NAME OF REGISTRAR

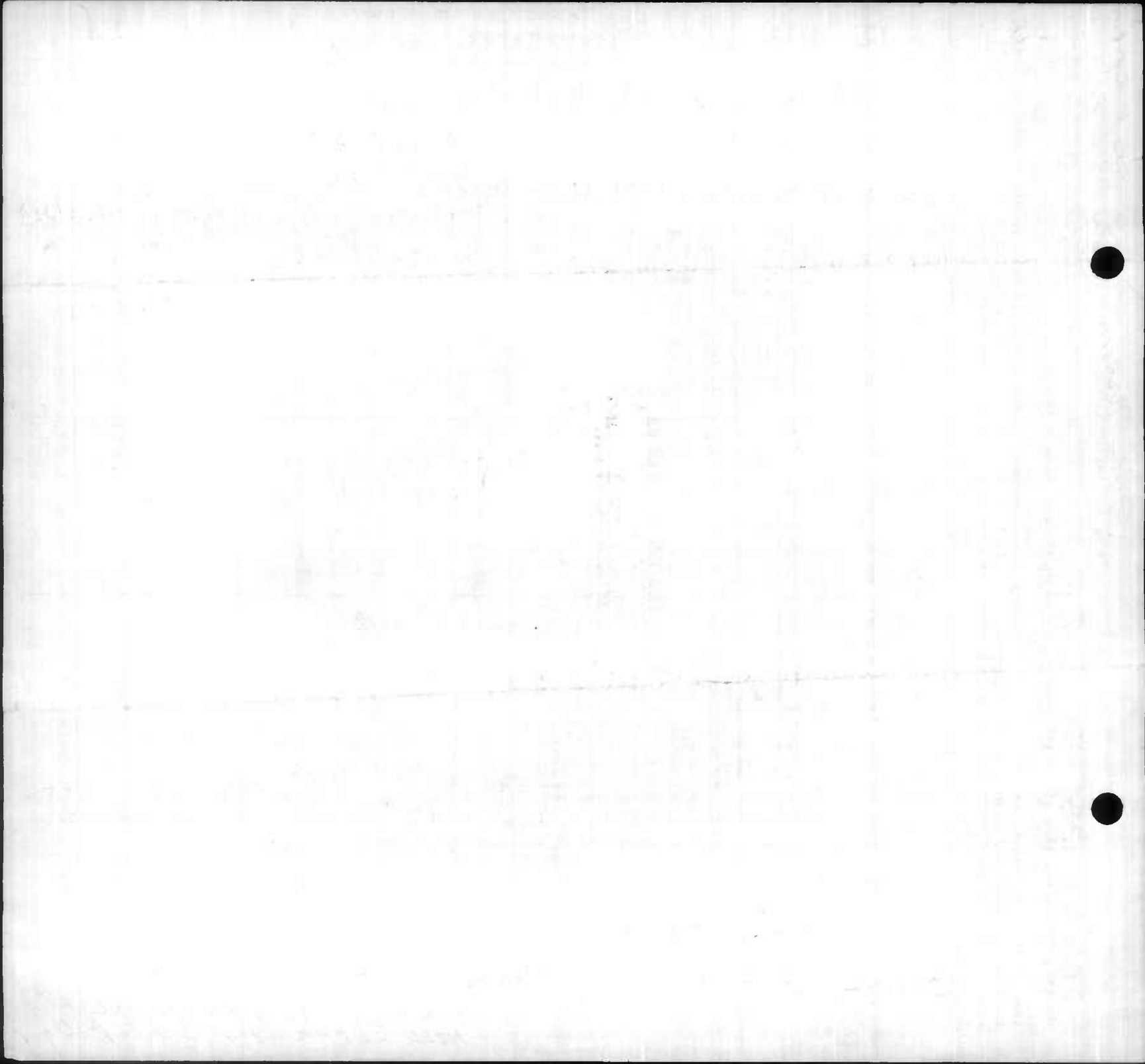
Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

JOHN O. MITCHELL & SONS, INC

ADDRESS

1900 EUTAW PL. BALTIMORE, MD.



1
J-145

65 1201 BALTIMORE CITY HEALTH DEPARTMENT 65 1201

BIRTH NO. _____ MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) JOSEPHINE JABLONSKI 2. DATE AND HOUR PRONOUNCED DEAD 1-31-65 1:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1736 Gough Street 21231

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL - DOA

5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED 8. DATE OF BIRTH DEC. 12 '1917 9. AGE (In years last birthday) 47

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANNING 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) BALTO. MD 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME MICHAEL POLEC 14. MOTHER'S MAIDEN NAME CARLINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT MICHAEL JABLONSKI 3006 GUILFORD AVE

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 161X I

(A) Bronchopneumonia DUE TO _____

(B) Carcinoma of larynx DUE TO _____

(C) _____

INTERVAL BETWEEN ONSET AND DEATH _____

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____

19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. _____ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

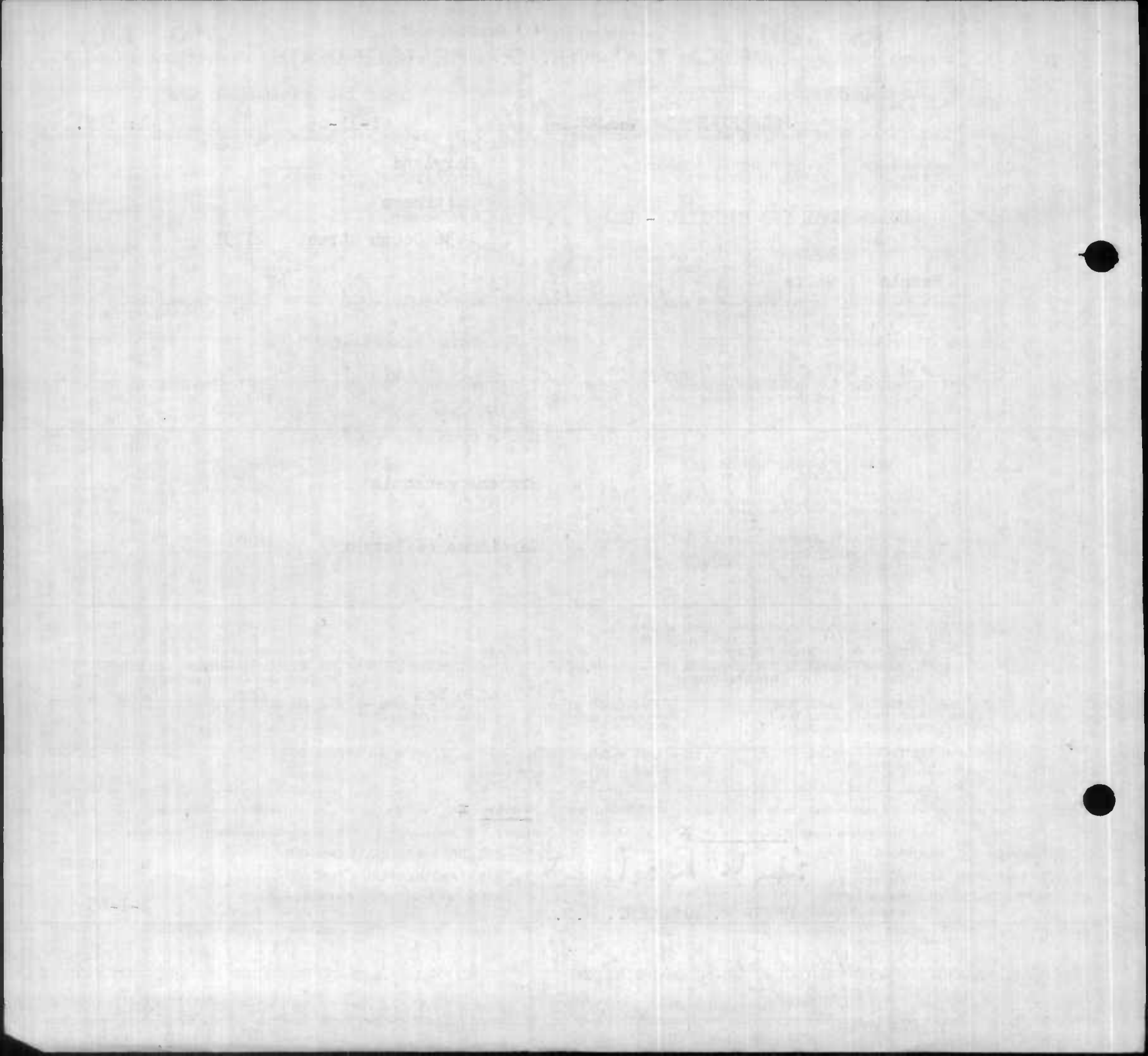
22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Peter W. Rieckert CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☐ EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D. ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 2-1-65

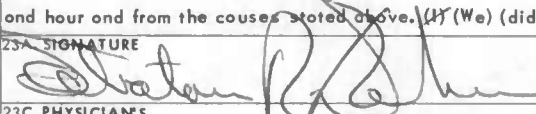
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 2-3 '1965 23C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM 23D. LOCATION (City, town, or county) (State) GERMAN HILL RD MD.

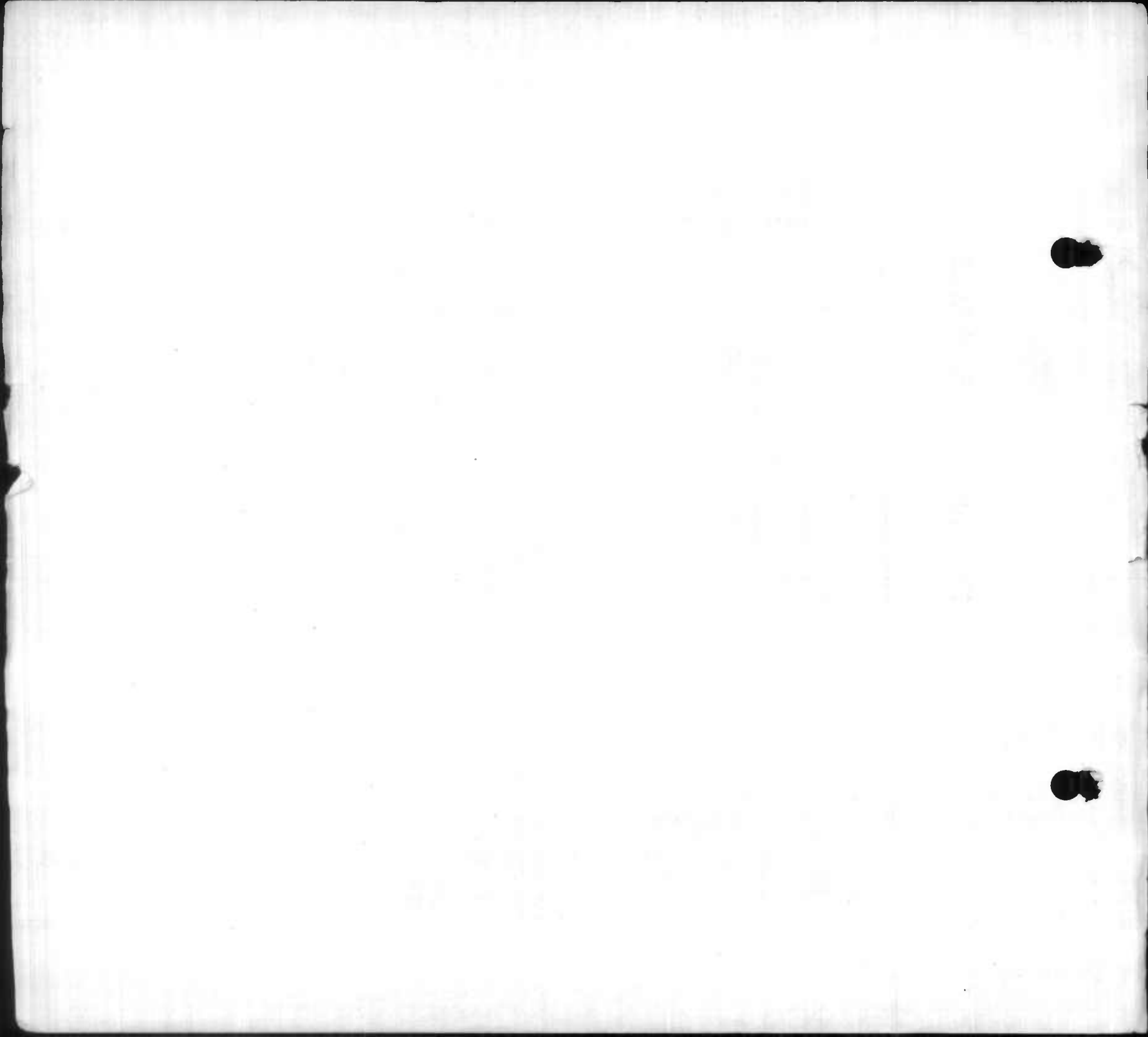
24A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 24B. NAME OF REGISTRAR Robert E. Farkes, M.D. 24C. FUNERAL DIRECTOR Marie Frankowski 1008 S. KENWOOD AVE BALTO. MD. 21224



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

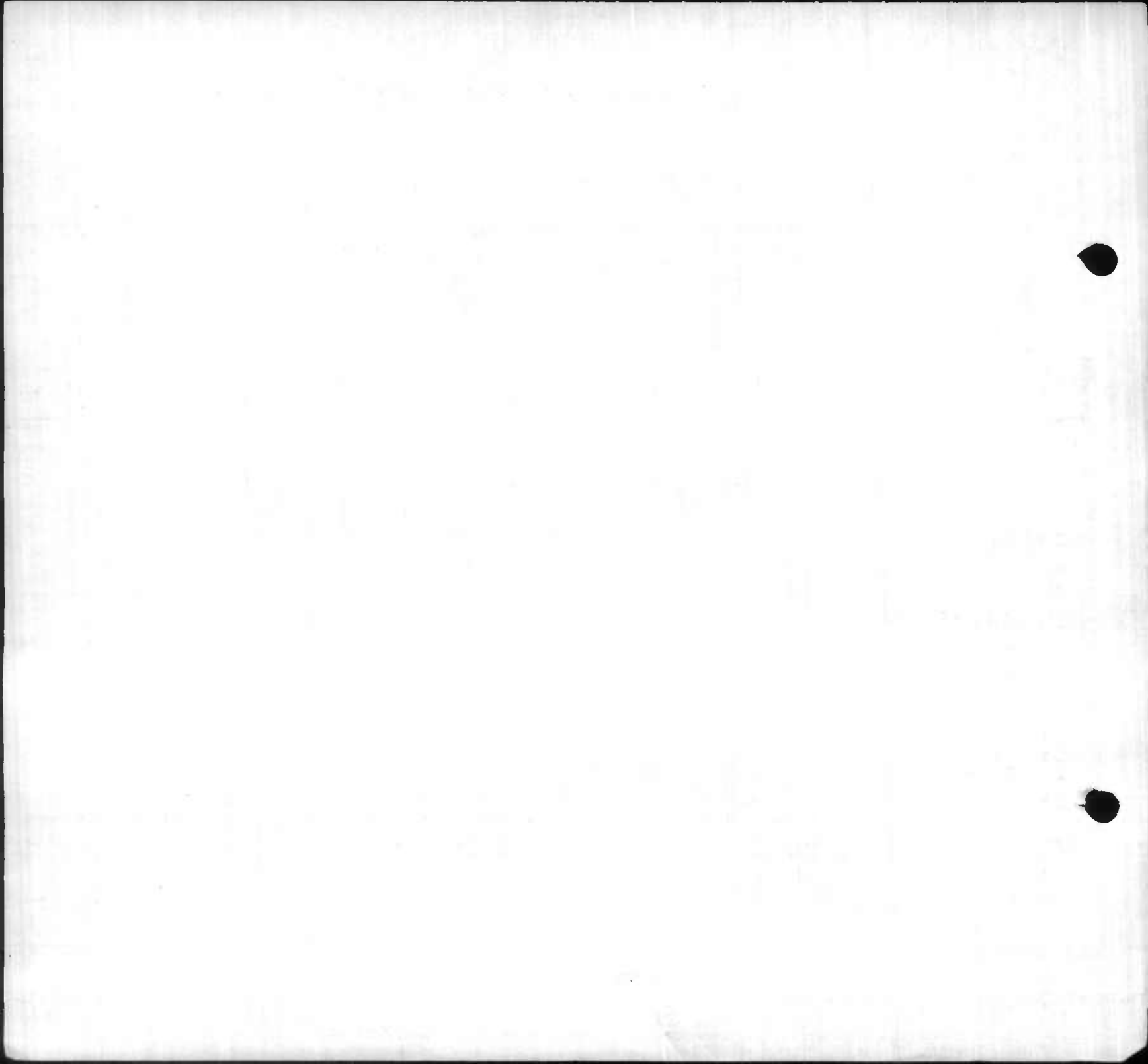
| 65 1202 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 1202 | |
|--|---------|--|--|---|---------------------------------|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | JULIAN KULISIEWICZ | | 1/31/65 8 ¹⁰ /P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | |
| | | | | MARYLAND | | H04 | |
| MERCY HOSP. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTO. | | | |
| D. STREET ADDRESS (If rural, give location) | | | | E. STREET ADDRESS | | | |
| | | | | 2221 ESSEX ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| M | W | DIVORCED | | 2/10/05 | 59 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| RIGGER | | BETHLEHEM STEEL | | BALTIMORE MD | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| ANTHONY KULISIEWICZ | | | | CAROLYN PRAGLOWSKI | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | | | JOSEPHINE PIEKARCZYK 2221 ESSEX ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 422.1 + 260X | | | | | | | |
| ANTECEDENT CAUSES | | | | (A) CONGESTIVE HEART FAILURE DUE TO SEPSIS, G I HEMORRHOAGE | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) ASCVD, Pneumonia, Gastric DUE TO ulcers | | | |
| II | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | HYPERGLYCEMIA - DIABETES MELLITUS | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that <u>HY</u> (this hospital) attended the deceased from <u>1/29</u> 19 <u>65</u> to <u>1/31</u> 19 <u>65</u> , that <u>HY</u> (we) last saw the deceased alive on <u>1/31</u> 19 <u>65</u> and that in <u>MY</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HY</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
|  | | | | 1/31/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| SALVATORE R. DONOHUE M.D. | | | | Mercy Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 2-4-65 | | HOLY ROSARY CEMETERY | | BALTIMORE CO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 2 1965 | | Robert E. Tarkenton | | JOHN M. WEBER & SONS INC | | 401 S. CHESTER ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1203 | |
|--|---------------------|--|---|---|---|
| BIRTH NO. 65 1203 | | | | Registered No. | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) John Lacey (LACHATCZYK) | | | | 2. DATE AND HOUR OF DEATH 2/1/65 2:45 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-03 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) 501 S. Patterson Pk. Ave | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4-8-1895 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Walter Lacey | | |
| 14. MOTHER'S MAIDEN NAME Helen Coleman | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 214-14-3648 | | | 17. INFORMANT ADDRESS Sylvester Lacey 4619 Shamrock Ave., Balto. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO Arteriosclerotic Hypertension | | | | INTERVAL BETWEEN ONSET AND DEATH 31 days unknown | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-1-65 19 to 2-1-65 19, that (I) (we) last saw the deceased alive on 2-1-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cesar R. Bariso | | | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) CESAR R. BARISO | | | | 23D. ADDRESS Church Home & Hospital - Balto. 31, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-4-65 | | 24C. NAME OF CEMETERY or CREMATORY SACRED HEART OF JESUS | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE Co. MD | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC | | | |
| 25D. ADDRESS 401 S. CHESTER ST | | | | | |



1
B-346

65 1204

BALTIMORE CITY HEALTH DEPARTMENT

65 1204

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT BUTLER

2. DATE AND HOUR PRONOUNCED DEAD

January 30, 1965 9:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

100 S. Catherine Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/7/05

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

He lper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilmer, Delaware

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Butle r

14. MOTHER'S MAIDEN NAME

Rachel Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lillian M. Butler 100 S. Catherine

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Massive intracerebral pontine
DUE TO hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined monner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/4/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

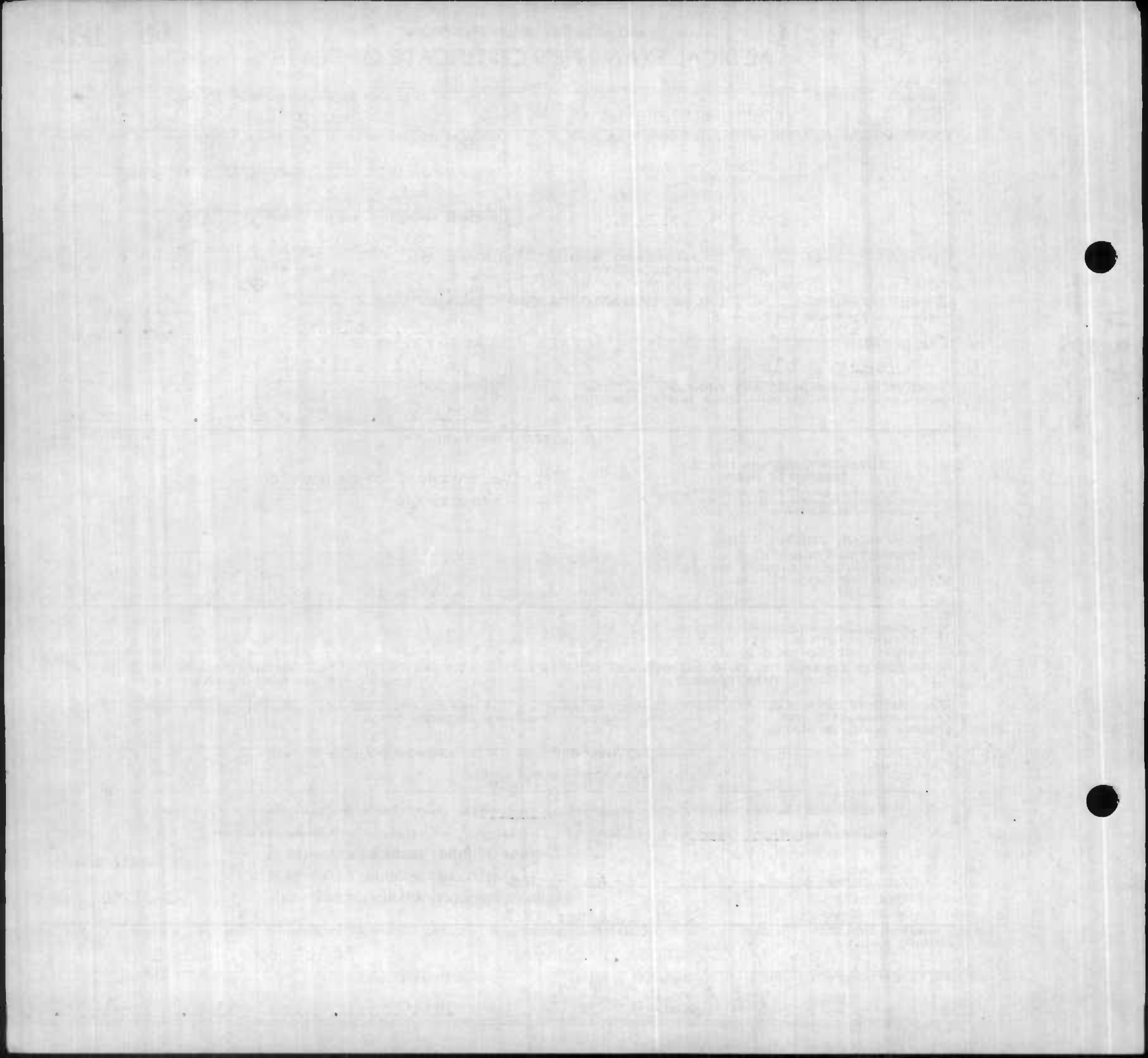
ADDRESS

FEB 2

1965

Robert E. Taylor, M.D.

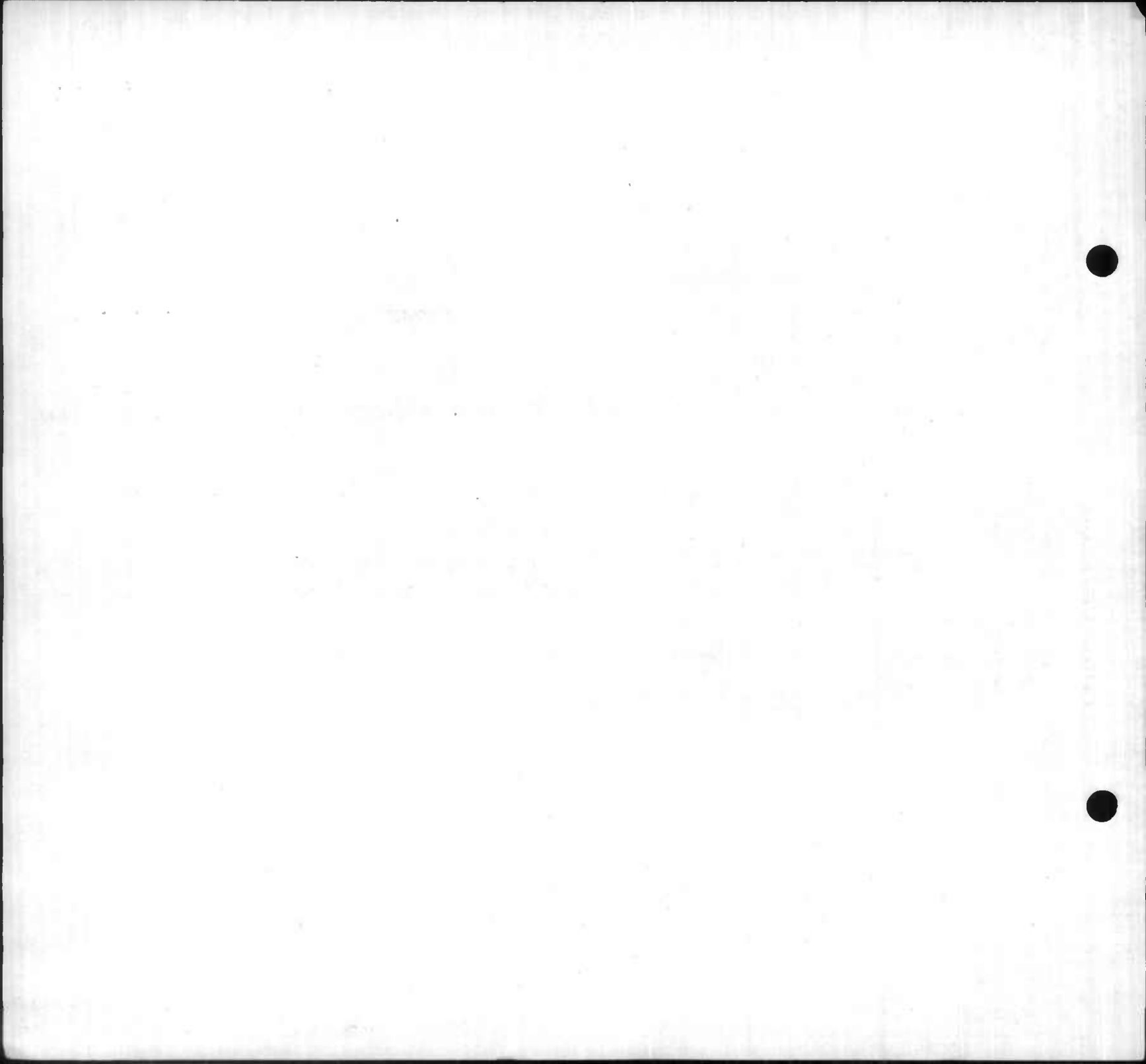
Charles A. Rice 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

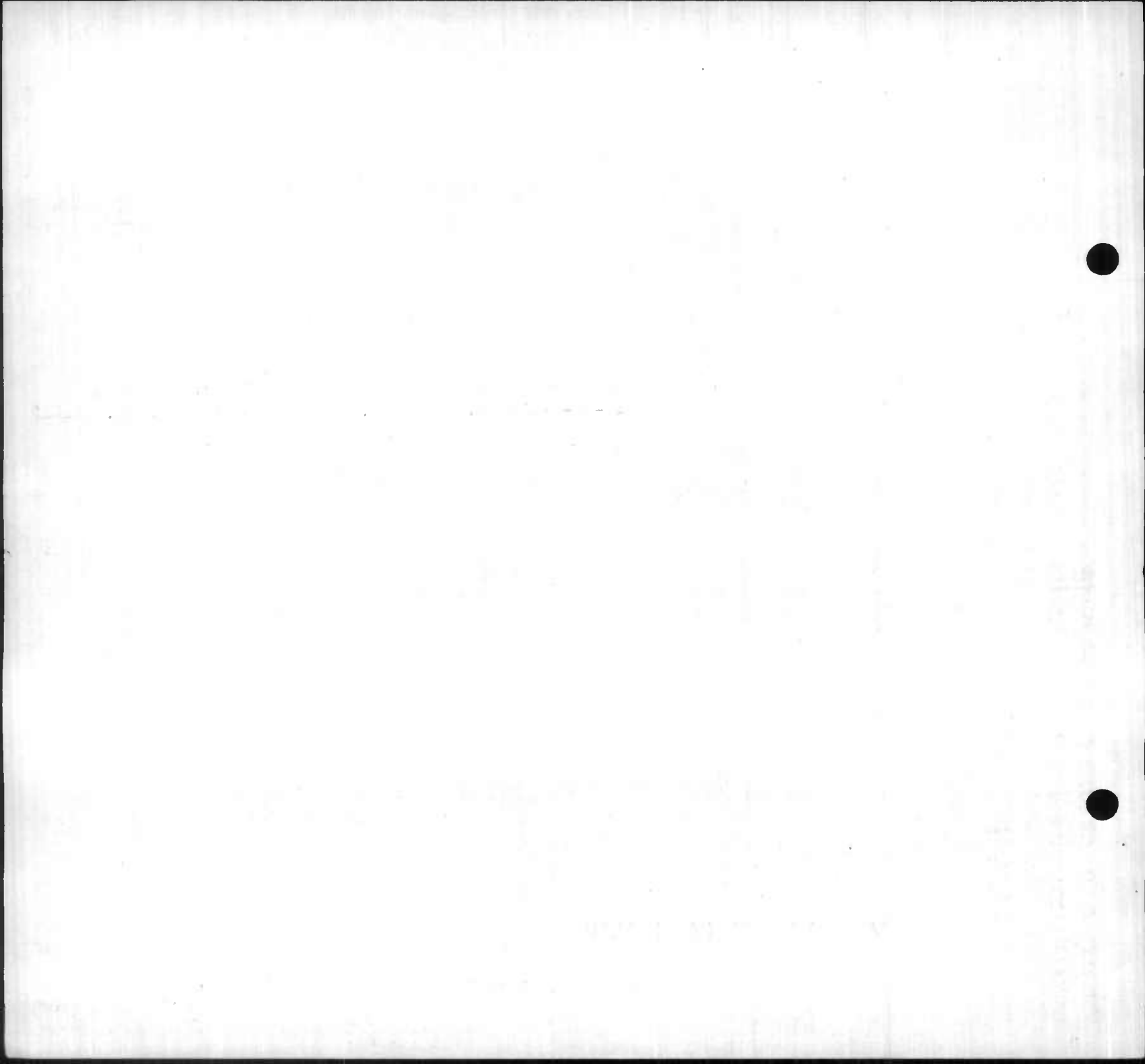
| | | | | | |
|--|------------------|---|--|--|---|
| BIRTH NO. 65 1205 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1205 | |
| 1. NAME OF DECEASED (Type or Print) Louise Lloyd | | | 2. DATE AND HOUR OF DEATH Jan. 29, 1965 5:00 P.M. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midtown Home Inc. 808 St. Paul St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 808 St. Paul Street Midtown Home | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 3/29/83 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Ruppert Gaybauer | | |
| 14. MOTHER'S MAIDEN NAME Anna ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | |
| 16. SOCIAL SECURITY NO. 213123554A | | | 17. INFORMANT Mrs. Catherine Bancroft Trenton, New Jersey | | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure Congestive Heart Failure Hypertensive - arteriosclerotic (CHD) Hemiplegia old - Sen. arteriosclerosis | | | 19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 21. INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from Jan 31 1955 to Jan 29 1965 , that (I) (we) last saw the deceased alive on Jan 29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Willard Appleford M.D. | | | 23B. DATE SIGNED 1/30/65 | | 23C. PHYSICIAN'S NAME (Type) Willard Appleford M.D. |
| 23D. ADDRESS 5501 Park Heights Dr. | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 2/2/65 | | | 24C. NAME OF CEMETERY or CREMATORY Landon Park Cemetery | | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR Wm. L. Jackson | | |
| 25D. ADDRESS Baltimore, Md. 17 | | | 25E. ADDRESS Baltimore, Md. 17 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

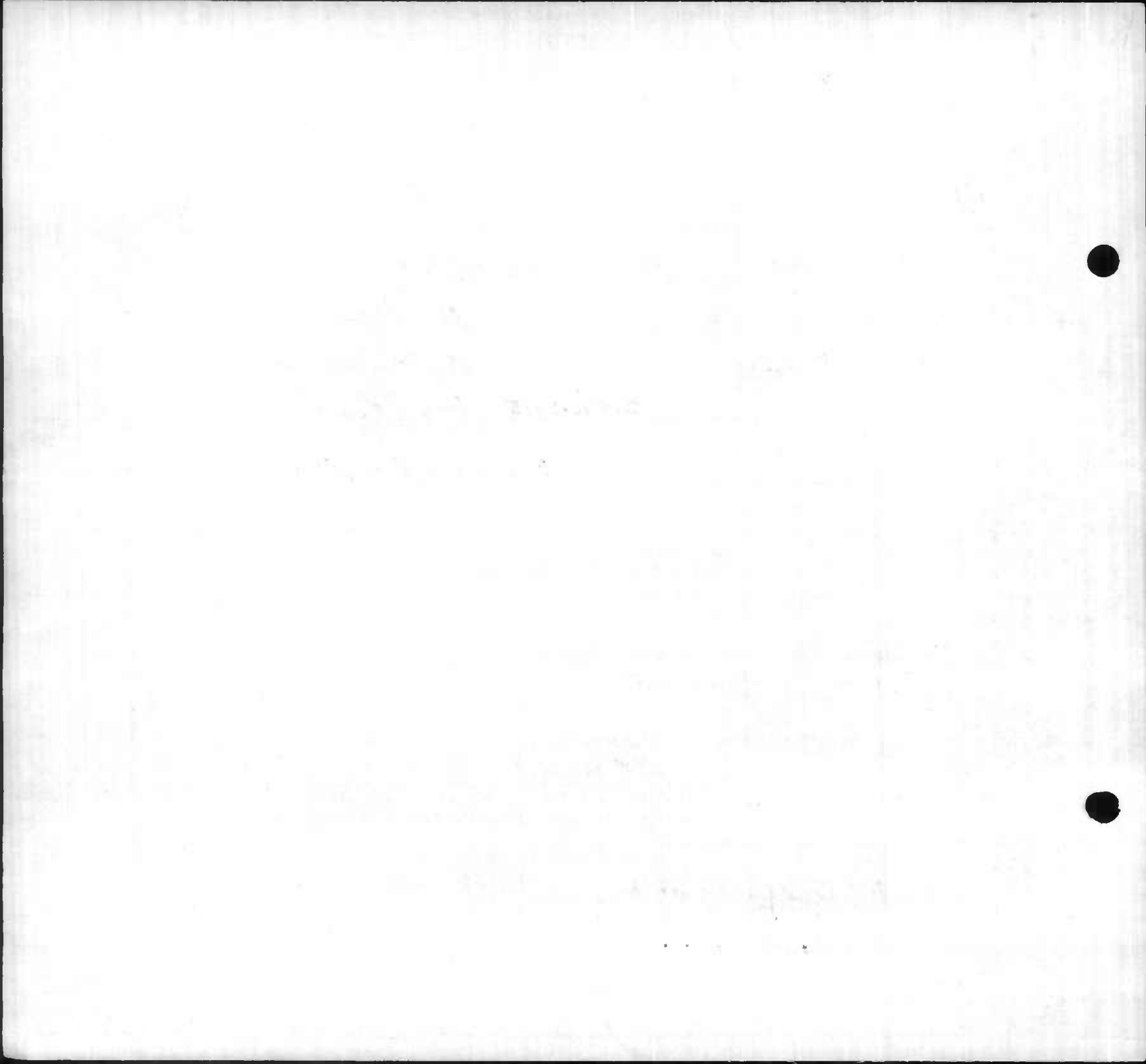
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|------------------|---|---|---------------------------------------|--|--|--------------------------|--|--------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1206 | | | | | |
| BIRTH NO. 65 1206 | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARY L. McLELLAN | | | | | 2. DATE AND HOUR OF DEATH JANUARY 31, 1965 11 30 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital BALTIMORE, Maryland | | | | | A. STATE Maryland | | | | | |
| | | | | | B. COUNTY 27-01 | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3510 Southern Ave. 14 | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/27/84 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME HENRY C. Duvall | | | | | 14. MOTHER'S MAIDEN NAME MARGARET METTEE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 213-05-3712B | | 17. INFORMANT Mr. Robert L. Rector | | | ADDRESS 400 Hopkins Road Baltimore, Md. 21212 | | |
| 18. 434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) congestive Heart Failure (B) Bronchopneumonia (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH 36 (+) Hours 36 (+) Hours |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 30 1964 to January 31 1965, that (I) (we) last saw the deceased alive on January 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE David Merritt Mac Millan | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1/31/65 | | |
| 23C. PHYSICIAN'S NAME (Type) DAVID MERRITT MAC MILLAN | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 2/3/1965 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fairbank | | | FUNERAL DIRECTOR Wm. J. Dickman & Son 1400 N. Avenue | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

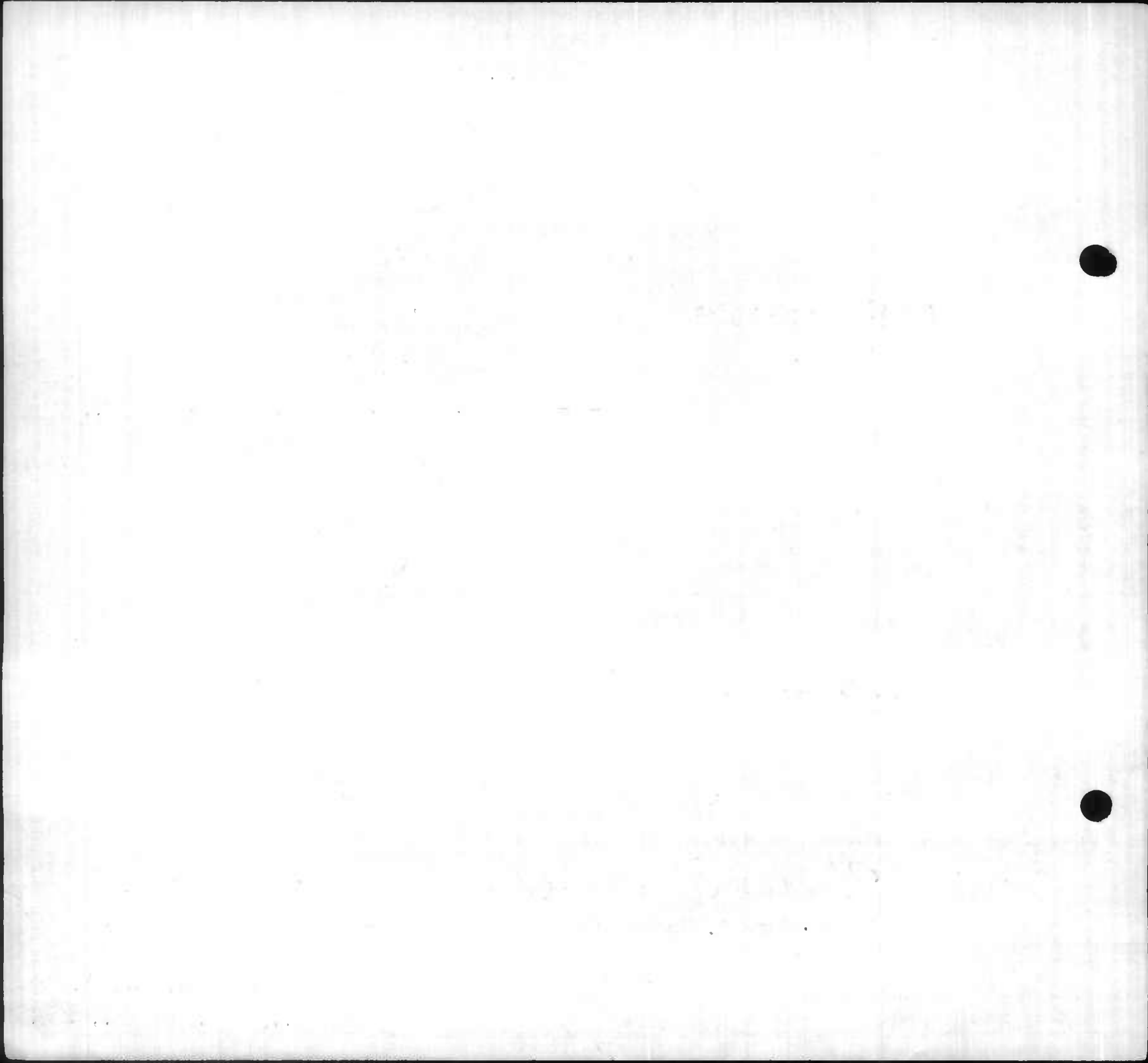
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | 65 1207 | |
|--|----------------------|--|--|--|-------------------------------|--|-----------------------------|--|--------------------------------------|----------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. | |
| BIRTH NO. 65 1207 | | M.E. CASE NO. KRENZER | | 1. NAME OF DECEASED (Type or Print) Krenzer John M | | | | 2. DATE AND HOUR OF DEATH 2-2-65 12:30 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ of Maryland Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland. B. COUNTY Frederick C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hegore D. STREET ADDRESS (If rural, give location) 60-00 | | | | | | | |
| 5. SEX M | 6. RACE Caucasion | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 10/19/91 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA. | | |
| 13. FATHER'S NAME John Krenzer | | | | 14. MOTHER'S MAIDEN NAME Martha Garber. | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 215-10-5415 | | 17. INFORMANT Hosp Record. | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Mesenteric Artery Occlusion - Massive DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | | | |
| (B) DUE TO | | | | (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 12-1-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Abd. | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-28-1965 to 2-2-1965, that (I) (we) last saw the deceased alive on 2-2-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Donald W. Snyder, M.D. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 2-2-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Donald D. Snyder, M.D. | | | | 23D. ADDRESS M.D. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/5/65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Hill | | 24D. LOCATION (City, town, or county) (State) Hegore Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR R. E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR H. C. Barton Walker, M.D. | | | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|------------------------------------|--|--|
| BIRTH NO. 65 1208 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1208 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) C. REID EDWARDS Dr. C. Reid Edwards | | 2. DATE AND HOUR OF DEATH Feb 1, 1965 11:15A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital (If not in hospital or institution, give street address or location) | | A. STATE MD | | | |
| | | B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 106 Longwood Road | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 9/19/88 | 9. AGE (In years last birthday) 76 | 10. CITIZEN OF WHAT COUNTRY? Medley, West Virginia |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician/surgeon | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME Phillip C. Edwards | | 14. MOTHER'S MAIDEN NAME Mary J. Vincent | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 216-01-1227 | | 17. INFORMANT Wife ADDRESS 21210 Mrs. Ruth C. Edwards, 106 Longwood Rd., City | |
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Pelvic abscess (A) Carcinoma of prostate DUE TO (B) Carcinoma of prostate DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 12/16/64 to 2/1/65 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/16/64 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Drainage pelvic abscess - yes | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-15-64 to 2-1-65 19____, that (I) (we) last saw the deceased 1/31/65 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Theodore G. Dodenhoff | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) Theodore G. Dodenhoff | | | | 23D. ADDRESS University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/3/1965 | | 24C. NAME OF CEMETERY or CREMATORY DEWID RIDGE CEMETERY | |
| 24D. LOCATION PIKESVILLE, Balto., Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Stewart & Mosen Co., 108 W. North Av., City. | | | |



1

65 1209

BALTIMORE CITY HEALTH DEPARTMENT

65 1209

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **GEORGE SMITH**

2. DATE AND HOUR PRONOUNCED DEAD **1/28/65 1:10 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **Church Home and Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY **Baltimore**

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **2-03**

6. STREET ADDRESS (If rural, give location) **1829 Aliceanna St.**

7. MARried, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH **August 17, 1899**

9. AGE (In years last birthday) **65**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Painter**

11. BIRTHPLACE (State or foreign country) **Baltimore Maryland**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **George Smith**

14. MOTHER'S MAIDEN NAME **Margaret Biggerman**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NO**

16. SOCIAL SECURITY NO. _____

17. INFORMANT **Mrs Fronie Berkeridge 622 S. Ellwood**

18. CAUSE OF DEATH

(A) **Arteriosclerotic cardiovascular disease**

(B) **Metastatic carcinoma of lung**

(C) _____

19. DATE OF OPERATION _____

20. AUTOPSY? (Yes or No) **no**

21. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? ☐

22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

24. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____

25. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

26. HOW DID INJURY OCCUR? _____

27. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

28. ACTUAL SIGNATURE **Werner U. Spitz** M.D.

29. CHIEF MEDICAL EXAMINER ☐

30. ASSISTANT MEDICAL EXAMINER ☐

31. ASSOCIATE MEDICAL EXAMINER ☒

32. DATE SIGNED **1/29/65**

33. BURIAL CREMATION, REMOVAL (Specify) **Burial**

34. DATE **2/3/65**

35. NAME OF CEMETERY or CREMATORY **Sacred Heart of Mary**

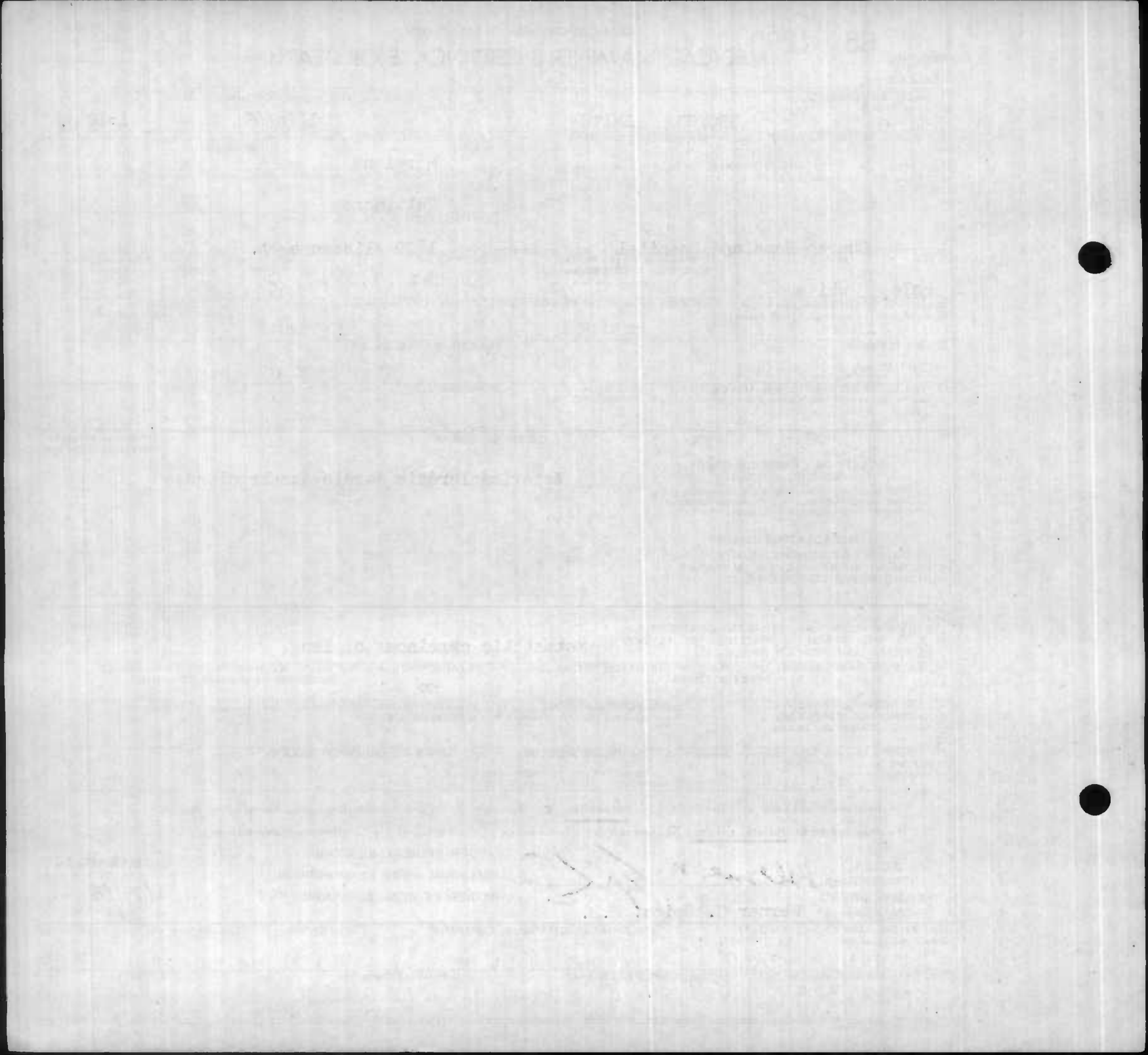
36. LOCATION (City, town, or county) (State) **Baltimore Maryland**

37. DATE REC'D BY HEALTH DEPT. **FEB 2 1965**

38. NAME OF REGISTRAR **Robert E. Taylor, M.D.**

39. FUNERAL DIRECTOR **HENRY SANDER & SONS INC.**

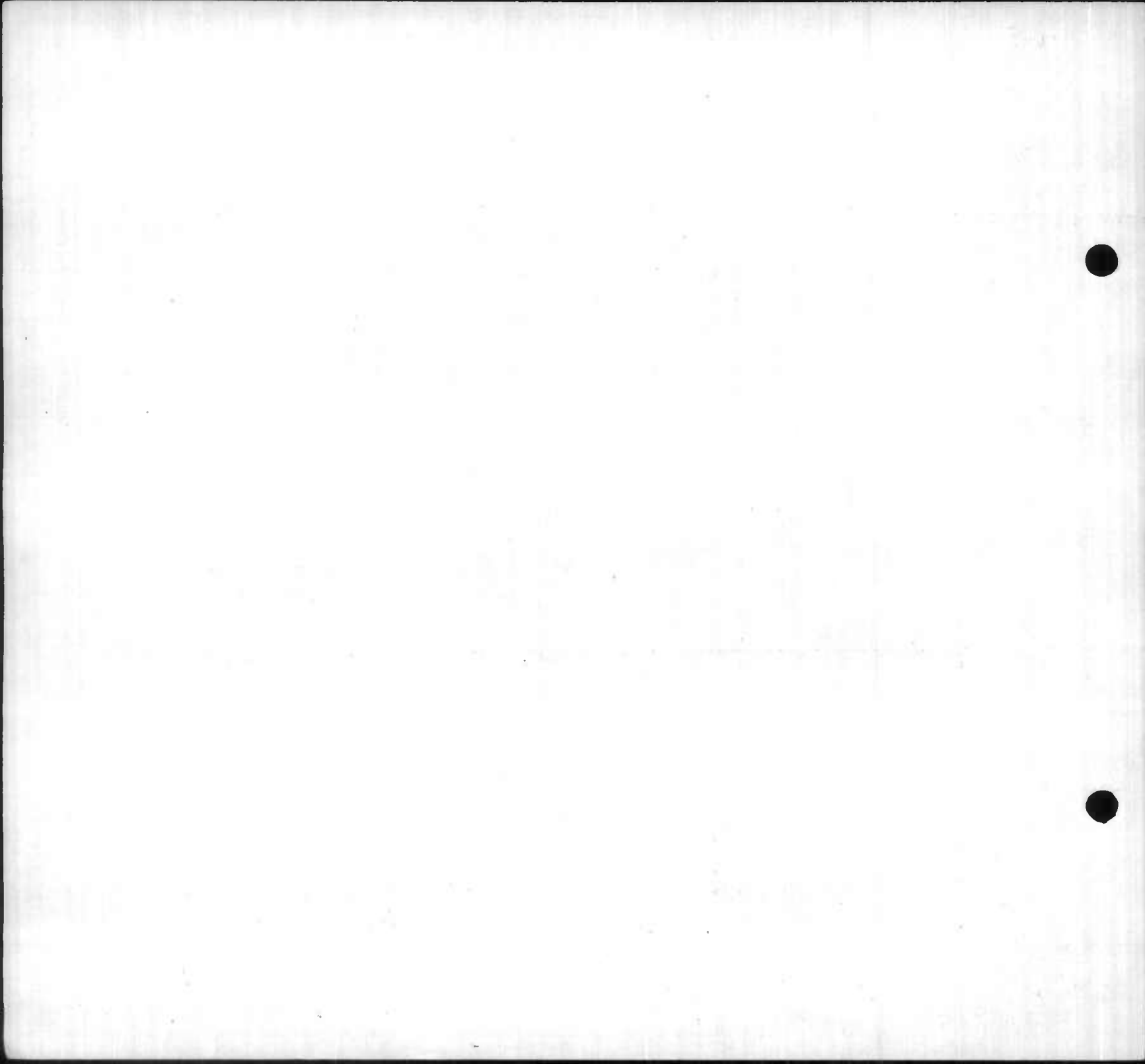
40. ADDRESS **BALTIMORE MARYLAND 21213**



FUNERAL DIRECTOR: IMPORTANT

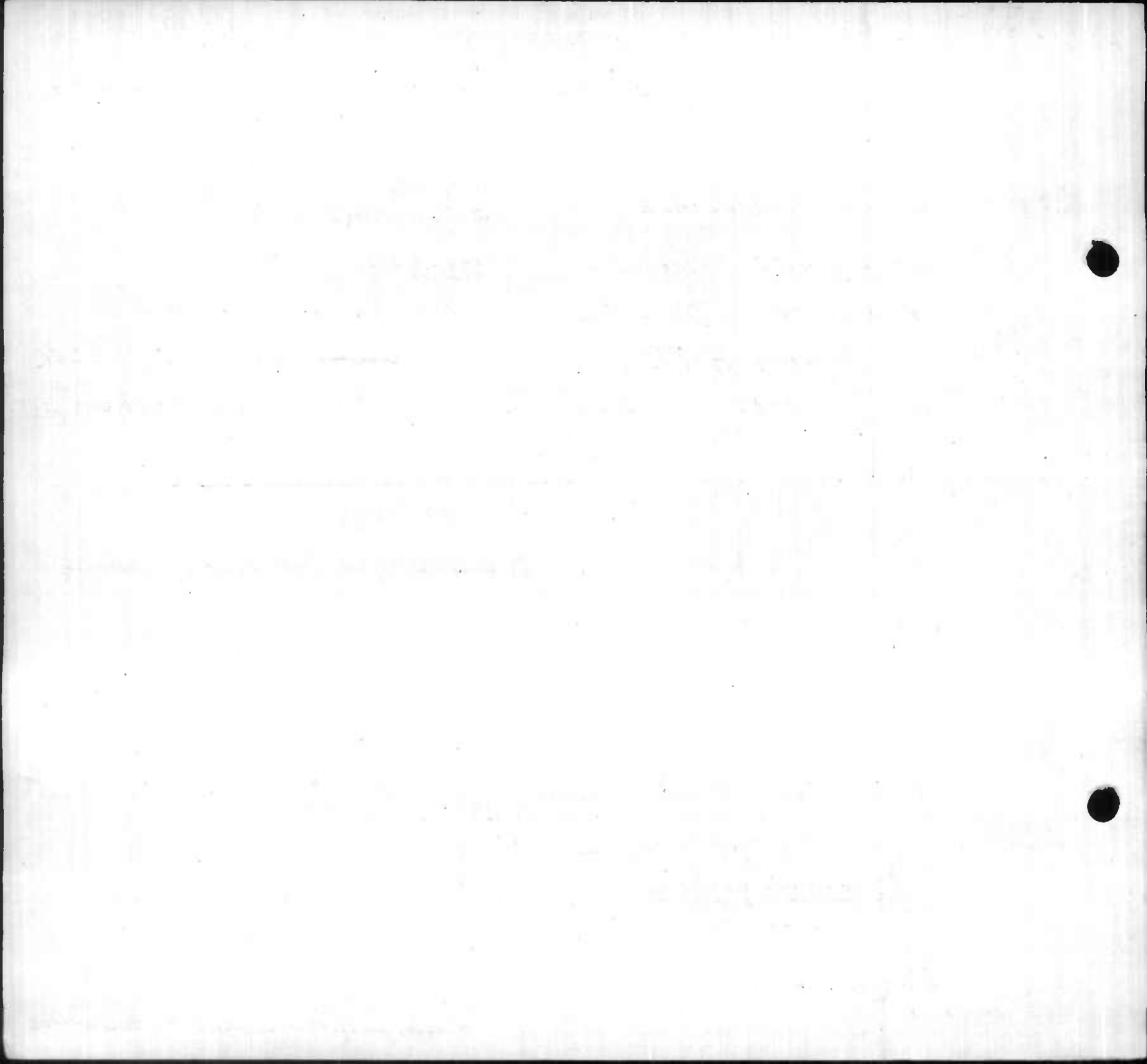
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1210 | |
|--|---------|--|------------------|--|--|
| 65 1210 | | | | 65 1210 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | WILLIAM L. MAGRUDER | | JANUARY 30, 1965 7 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | MARYLAND | |
| 1721 EAST 31st STREET | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE 21218 | |
| | | D. STREET ADDRESS (If rural, give location) | | 1721 EAST 31st STREET | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min. |
| M | W | WIDOWED | JULY 9, 1886 | 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| WAITER Retired | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Unknown Magruder | | Unknown | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 213 03 52 28 | | Mrs Elizabeth Ramsay 1721 E. 31st ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Sudden | |
| ANTECEDENT CAUSES | | (B) DUE TO | | 10 yrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Generalized arteriosclerosis | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to 1/30/65 that (I) (we) last saw the deceased alive on 1/2/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Conrad L. Richter | | | | 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Conrad L. Richter | | 3128 Harford Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/2/65 | | Loudon Park | |
| | | | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 2 1965 | | R. E. Taylor, M.D. | | HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1211 | |
|--|-------------------------|---|---|---|---|
| BIRTH NO. 65 1211 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MADLINE KATHERINE FLEMING | | | |
| 2. DATE AND HOUR OF DEATH JANUARY 31, 1965 12:45 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2540 WILKENS AVE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2540 WILKENS AVE | | | |
| 5. SEX FEMALE | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH MAY 29, 1889 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ADAM HITTEL | | | |
| 14. MOTHER'S MAIDEN NAME MADELINE MILLER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE | | | |
| 16. SOCIAL SECURITY NO. 212-03-7572B | | 17. INFORMANT HARRY FLEMING ADDRESS 2540 WILKENS AVE | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) coronary occlusion sudden (B) Cardiovascular Disease 5 yrs (C) Generalized arteriosclerosis 10 yrs | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 55 to January 31 19 65 , that (I) (we) last saw the deceased alive on January 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Johnnie L. Quiche | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) J. KUDIRKA | | 23D. ADDRESS 2151 Wilkens Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR GEORGE L. Schwab ADDRESS Francis St. Miller 2101 Frederick Ave | |



1
N. 620

65 1212

BALTIMORE CITY HEALTH DEPARTMENT

65 1212

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)DULANEY
WILLIAM ~~DAVE~~ NORRIS JR.

2. DATE AND HOUR PRONOUNCED DEAD

1-31-65

2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2708 Wilkens Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2708 Wilkens Avenue 21223

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Aug 27, 1900

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ACCOUNTANT

10B. KIND OF BUSINESS OR INDUSTRY

CLERICAL

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM NORRIS

14. MOTHER'S MAIDEN NAME

Annie Huster

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES World War I

16. SOCIAL
SECURITY NO.

217-44-0499

17. INFORMANT

ADDRESS

Gertrude Norris 2708 Wilkens Ave

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2-4-65

23C. NAME OF CEMETERY or CREMATORY

NEW CATHEDRAL

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE MD

24A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

GEO. L. SCHWAB FUNERAL HOME
Francis H. Miller 2101 Madison Ave

cdg: 31-65-661

BALTIMORE CITY HEALTH DEPARTMENT

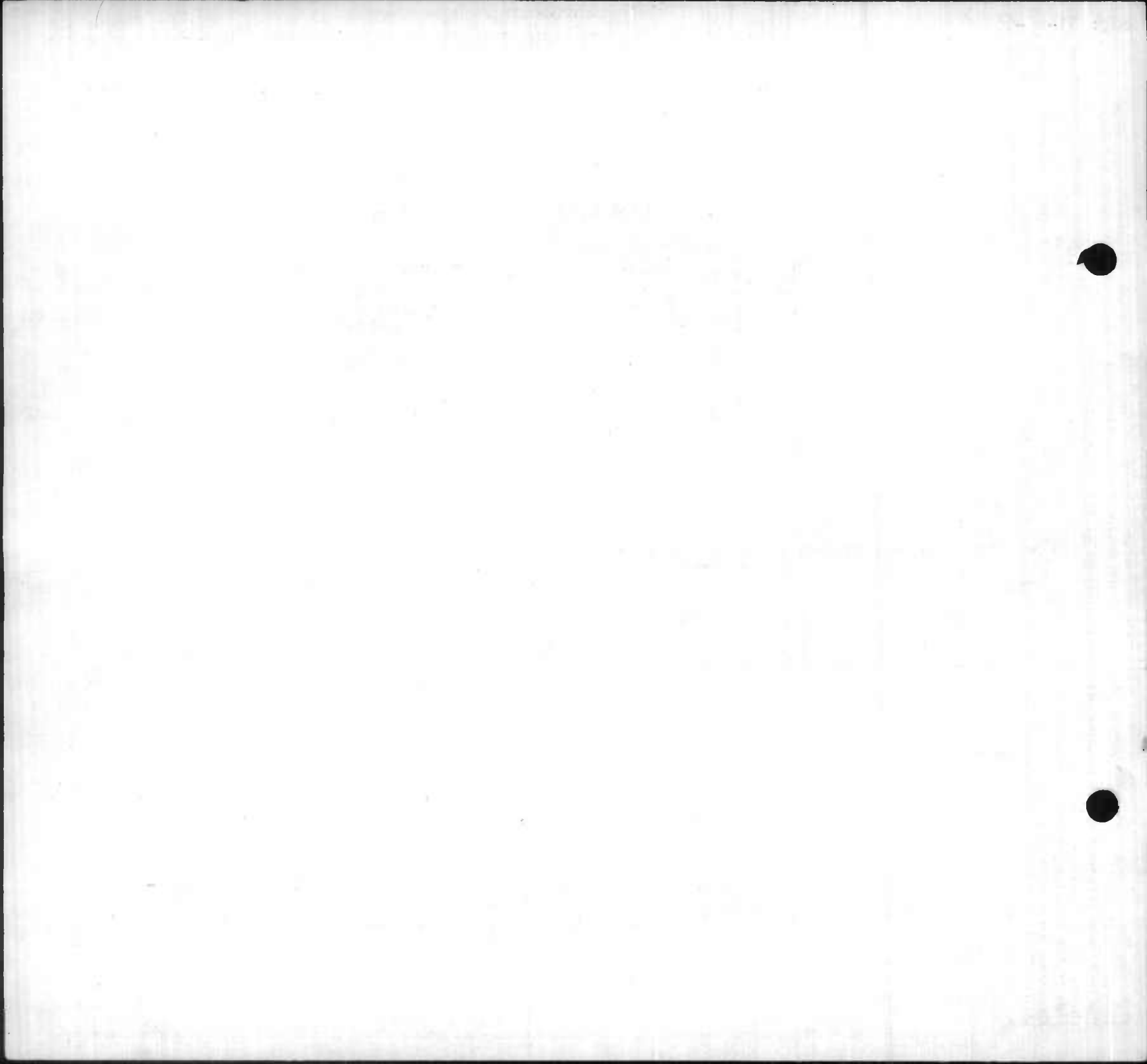
CERTIFICATE OF DEATH

Registered No. 65 1213

| | | | |
|--|-------------------------|--|------------------------------------|
| BIRTH NO. 65 1213 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) Wilmer Smith | | 2. DATE AND HOUR OF DEATH January 30, 1965 2:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1124 Cleveland Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 2-24-09 |
| 9. AGE (In years last birthday) 55 | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman | | 10B. KIND OF BUSINESS OR INDUSTRY Glass Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wm. E. Smith | | 14. MOTHER'S MAIDEN NAME Cecil C. Earling | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 21705 1707 | |
| 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue | | 18. CAUSE OF DEATH Neurosyphilis | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH 8 years | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 9, 1961 to January 30, 1965 , that (I) (we) last saw the deceased alive on January 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE R. Cooke | | 23B. DATE SIGNED 1-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) Robert Cooke | | 23D. ADDRESS 4940 Eastern Avenue 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-3-65 | |
| 24C. NAME OF CEMETERY OR CREMATORY London Park | | 24D. LOCATION (City, town, or county) (State) Balt | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | |
| 25C. FUNERAL DIRECTOR John J. Carman + Son Inc | | 25D. ADDRESS Baltimore Md | |

FUNERAL DIRECTOR: IMPORTANT

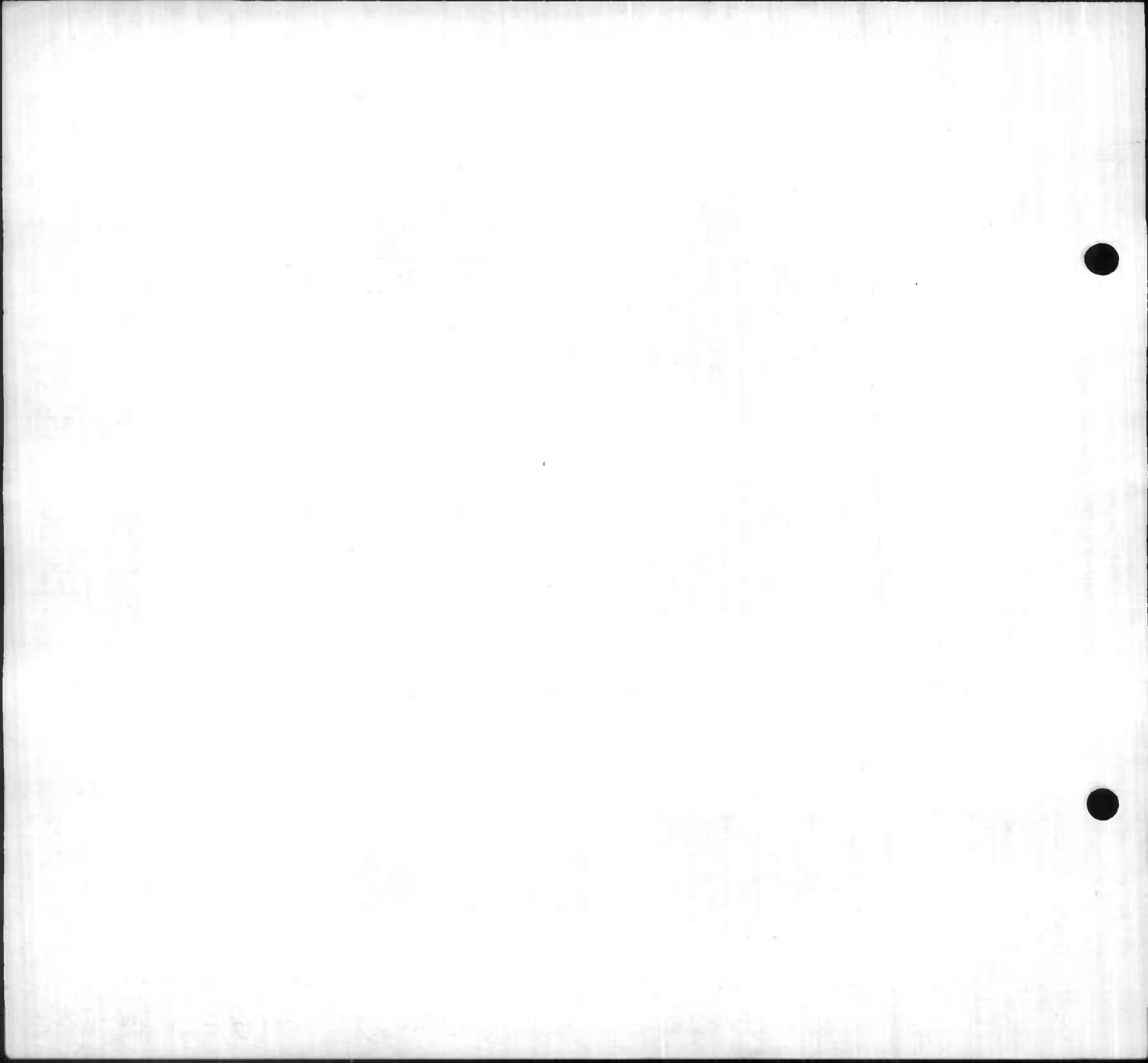
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1214 | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 65 1214 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Peters, Emma</i> | | 2. DATE AND HOUR OF DEATH <i>1-31-65</i> <i>2:20</i> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>X</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE CITY</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> | | D. STREET ADDRESS (If rural, give location) <i>1407 GOUGH STREET</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>5-10-94</i> | 9. AGE (In years last birthday) <i>70</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>@ home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ind</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Edward Kearney</i> | | 14. MOTHER'S MAIDEN NAME <i>LENA LUDECK</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>L</i> | | 17. INFORMANT <i>Harry Lee Peters - Above</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>520X I</i> | | CAUSE OF DEATH (A) <i>Pulmonary Embolization</i> DUE TO (B) <i>Obstructive Airway Disease</i> DUE TO (C) <i>unknown</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>none</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>20% Pneumothorax</i> | | | |
| 19A. DATE OF OPERATION <i>1. 31. 65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pneumothorax</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-30</i> 19 <i>65</i> to <i>1-31</i> 19 <i>65</i> , that (I) (he) last saw the deceased alive on <i>2:15</i> <i>1-31</i> 19 <i>65</i> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>W.T. Maxson</i> | | | | 23B. DATE SIGNED <i>1-31-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>W.T. MAXSON</i> | | 23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>2-3-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fairley, M.D.</i> | |
| 25C. FUNERAL DIRECTOR <i>John J. Conner</i> | | 25D. ADDRESS <i>Baltimore Md</i> | | | |



G-355

65 1215

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

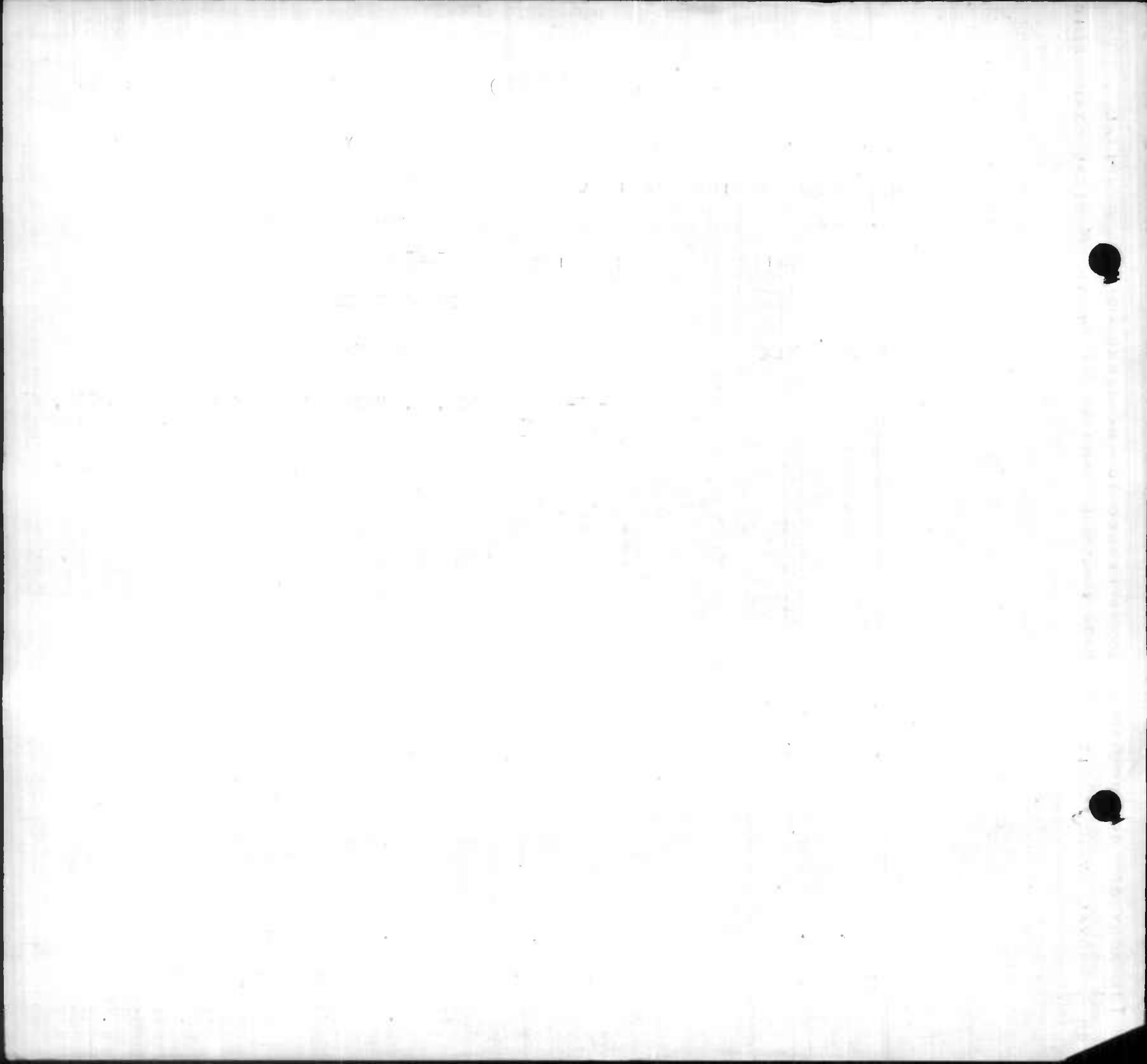
65 1215

| | | | |
|---|--|---|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| RAYMOND PETER GETTMAN | | January 28 1965 12:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| Baltimore City Hospitals | | Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 4100 E. Lombard Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH |
| Male | White | SINGLE | 5-3-1898 |
| 9. AGE (In years last birthday) | | 10. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 66 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| NEVER EMPLOYED | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| PETER GETTMAN | | EMMA GEHART | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | | |
| 17. INFORMANT | | ADDRESS | |
| Mrs. Lillian J. Gay | | Manhattan Beach, Md. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| Arteriosclerotic Cardiovascular Disease. | | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Charles S. Petty, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME of CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| BURIAL | 2-2-65 | SCHWARTZ'S Cem. | BALTO., MD. |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR | ADDRESS |
| FEB 2 1965 | Robert E. Taylor, Jr. | Stanley Miller | 2334 Jefferson St. |

VALLEY FORDS

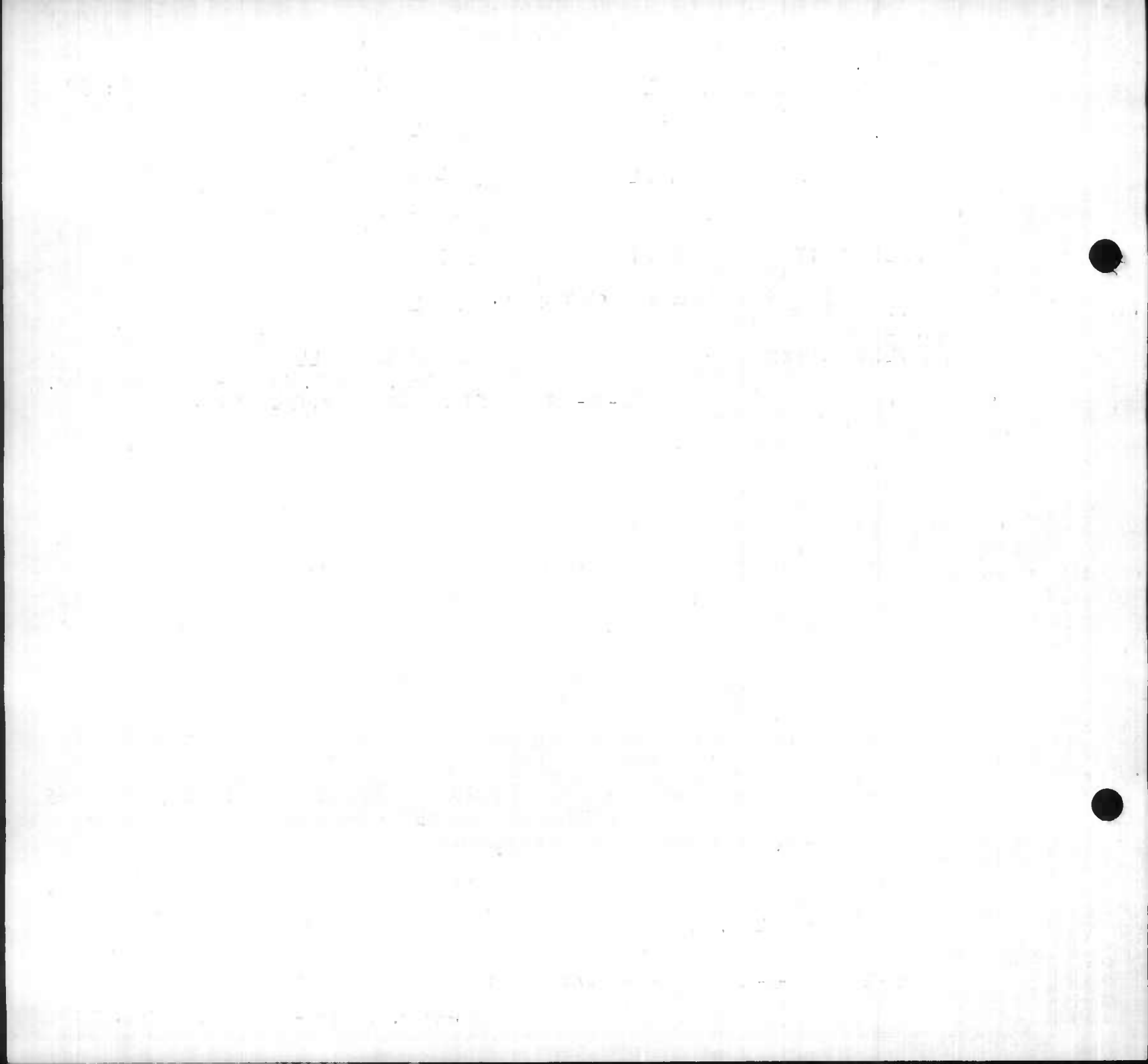
VALLEY FORDS

| | | | | | | | |
|---|------------------|--|-----------------------------|--|--|---|-------------------------------------|
| BIRTH NO. 65 1216 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH X | | Registered No. 65 1216 | |
| M.E. CASE NO. | | E. | | 2. DATE AND HOUR OF DEATH | | 1-28-65 4:05PM M. | |
| 1. NAME OF DECEASED (Type or Print) | | ARTHUR GABLE (XXXXXX) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | NEW JERSEY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| THE JOHNS HOPKINS HOSPITAL | | | | ROSELLE | | D. STREET ADDRESS (If rural, give location) | |
| 724 GOLF TERRACE | | | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-15-05 | 9. AGE (In years last birthday) 59 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ARTHUR GABLE | | 14. MOTHER'S MAIDEN NAME REBECCA BISNER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 152-01-8861 | |
| 17. INFORMANT ELIZ. W. GABLE | | ADDRESS 724 GOLF TERRACE ROSELLE, NJ | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CALCIFIC AORTIC STENOSIS INTERVAL BETWEEN ONSET AND DEATH LONGSTANDING | | 19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION 3/28/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Stenosis | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 1/28/65 to 1/28/65 that (we) last saw the deceased alive on 1/28/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE H. D. AGNEW | |
| 23B. DATE SIGNED 1/28/65 | | 23C. PHYSICIAN'S NAME (Type) H. D. AGNEW | | 23D. ADDRESS 601 N. BROADWAY | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | |
| 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY EVERGREEN CEMETERY | | 24D. LOCATION (City, town, or county) (State) ELIZABETH, NEW JERSEY | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR HOWARD H. HUBBARD | | ADDRESS 4107 WILKENS AVE. 21229 | | 25D. FUNERAL DIRECTOR ADDRESS 4107 WILKENS AVE. 21229 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

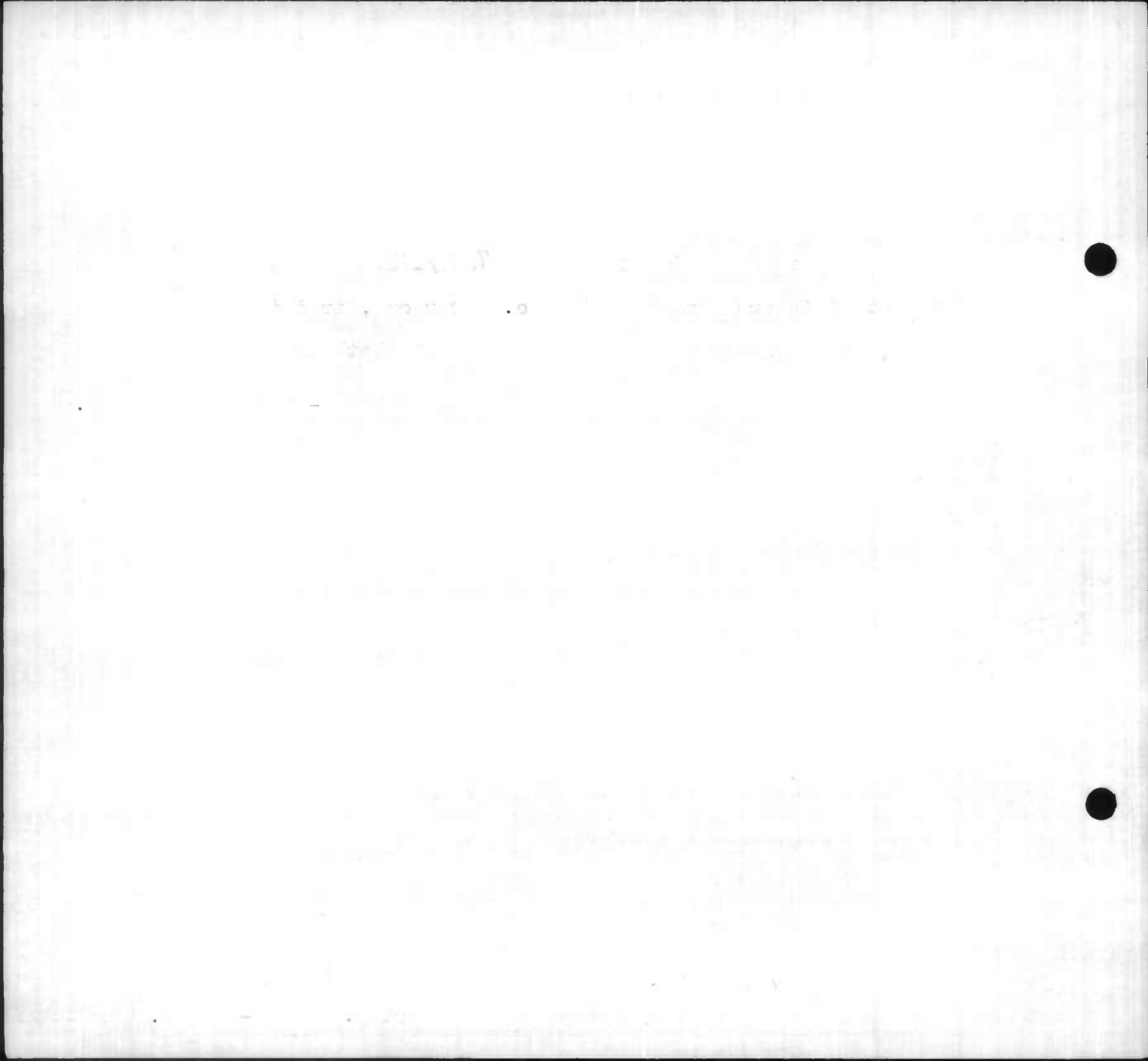
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|---|---|--|---|------------------------------|--|--|
| 65 1217 CERTIFICATE OF DEATH | | | | | Registered No. 65 1217 | | | | |
| BIRTH NO. 65 1217 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN JACOB ARNOLD | | | | | 2. DATE AND HOUR OF DEATH 1 28 65 8:45P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 D. STREET ADDRESS (If rural, give location) 917 COURTNEY ROAD | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3 7 84 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Cabinet Maker | | | 10B. KIND OF BUSINESS OR INDUSTRY Monroe Upholstery Co. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME GOTTEIB ARNOLD | | | 14. MOTHER'S MAIDEN NAME Marguerite Buell | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-03-3870 | | 17. INFORMANT Mrs. Emma V. Arnold-917 Courtney Rd. 27 ST AGNES HOSPITAL RECORDS | | | | |
| 18. 434.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Concussion Heart Failure (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Blateral pyelonephritis (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1 20 1965 to 1 28 1965 , that (I) (we) last saw the deceased alive on 1 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Raphael C. Myers Jr M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) RAPHAEL C. MYERS JR M.D. | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-65 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave. 21229 | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1218</u> | |
|--|----------------------|---|-----------------------------------|---|---|
| BIRTH NO. <u>65 1218</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>2-2-65</u> <u>2 40</u> A.M. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>THOMAS WOODROW GWALTNEY</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1011 W. Mulberry St.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>7/23/1918</u> | 9. AGE (In years last birthday) <u>46</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Carson, Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>James Gwaltney</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Green</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT ADDRESS <u>Hugh Gwaltney-3025 Walbrook Ave.</u> | | | |
| 18. <u>491 X OF 322.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Hypotension</u> DUE TO (B) <u>E. coli septicemia</u> DUE TO (C) <u>E. coli bacteremia + shock</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 d.</u> <u>10 d.'s</u> <u>> 2 wks.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic alcoholism</u> | | | | | |
| 19A. DATE OF OPERATION <u>3-25-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RESPIRATORY INSUFFICIENCY</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-21-65</u> 19 <u>65</u> to <u>2-2</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2-2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Michael G. Hayes</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>2-2-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Michael G. Hayes</u> | | | | 23D. ADDRESS <u>UNIVERSITY HOSPITAL, BALTO., MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/6/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore Maryland</u> | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter-3035 W. North AVE.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

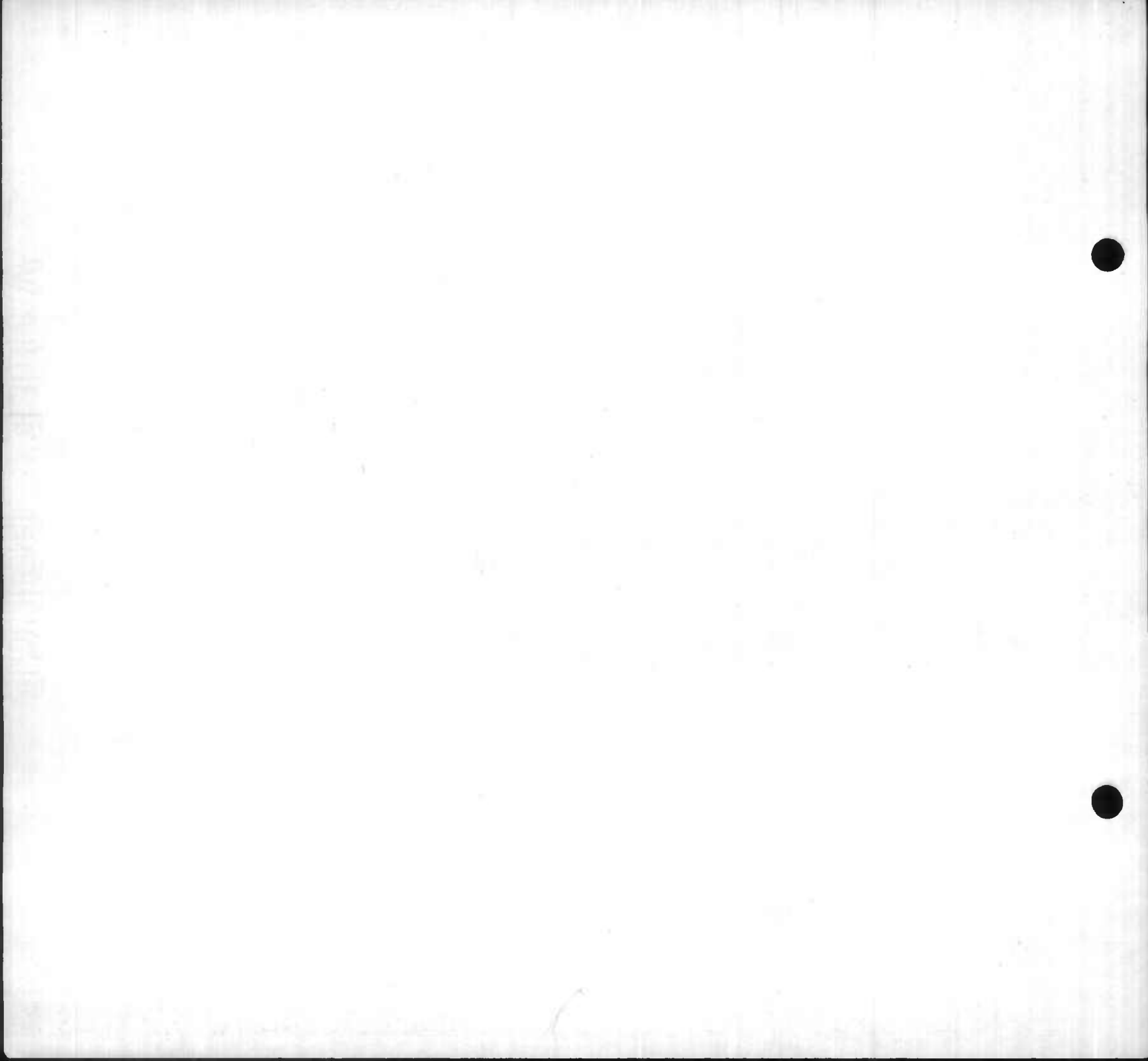
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 1219 | |
|--|---------------------------|---|--|--|---|
| BIRTH NO. 65 1219 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Julia Brooks | | | 2. DATE AND HOUR OF DEATH Jan 29, 1965 8:35 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3402 Woodbrook Ave. | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct. 15, 1908 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Magnolia N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Daniel Merritt | | | 14. MOTHER'S MAIDEN NAME Melissa Brinson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 213-20-3685 | | 16. SOCIAL SECURITY NO. 213-20-3685 | | 17. INFORMANT Mr. Excell Brooks-3402 Woodbrook Ave. | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery disease Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 30 minutes 7 years | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 29, 1965 to Jan 29, 1965 , that (I) (we) last saw the deceased alive on 1. 29. 1965 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James D. Carr | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1.30.65 |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS M.D. 1427 Madison Ave Balto. 17, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/65 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Baltimore Co. Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Herbert B. Nutter-3035 W. North Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|
| BIRTH NO. 65 1220 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1220 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Robertson, Joseph W. (Phlebotomist)</i> | | | | | 2. DATE AND HOUR OF DEATH <i>2-1-65 1:45 a.m.</i> | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>JOHNS HOPKINS HOSP</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>10-02</i> | | | | | | | | | | | | | | |
| 5. SEX <i>M</i> | | | | | 6. RACE <i>N</i> | | | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemp.</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) <i>Laditton N.C.</i> | | | | | | | | | |
| 13. FATHER'S NAME <i>SYDNEY ROBERTSON</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>SIMS</i> | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | | 16. SOCIAL SECURITY NO. <i>213-09-1641</i> | | | | | 17. INFORMANT <i>to Elizabeth Brown 914 N Eden St</i> | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>581.11-260X</i> | | | | | CAUSE OF DEATH (A) <i>Acute Pancreatitis</i> (B) <i>Laennec's Cirrhosis</i> (C) <i>Alcoholism</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>4 years</i> | | | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i> | | | | | 19A. DATE OF OPERATION <i>2</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/28</i> 19 <i>65</i> to <i>2/1</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>1/31</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE <i>John F. Bigger, Jr MD</i> M.D. | | | | | 23B. DATE SIGNED <i>2-1-65</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN F. BIGGER, JR MD</i> | | | | | 23D. ADDRESS <i>Johns Hopkins Hosp.</i> | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | 24B. DATE <i>2/4/65</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY <i>Paul Natl Cemetery</i> | | | | | | | | | |
| 24D. LOCATION (City, town, or county) (State) <i>5501 Fredrick Ave.</i> | | | | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1965</i> | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i> | | | | | | | | | |
| 25C. FUNERAL DIRECTOR <i>Frank E. Clicken 1129 N. ...</i> | | | | | 25D. ADDRESS <i>1129 N. ...</i> | | | | | | | | | | | | | | |



65 1221

BALTIMORE CITY HEALTH DEPARTMENT

65 1221

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BEN DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

2-1-65

12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1824 E. EAGER STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1824 E. Eager Street 21205

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 25,

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemp.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Rockhill S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Eli Davis

14. MOTHER'S MAIDEN NAME

Addie Davis ne Shubley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Bessie Davis

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Bilateral pulmonary tuberculosis

Tuberculosis of larynx

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. FIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Feb 4/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem. A.A. County Md.

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Milton E. Elickson 1129 Madison

ADDRESS

WALTER F. COMPTON



L-400-53 AM
35-46-53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1222

BIRTH NO. 65 1222

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John Edward Lyle

2. DATE AND HOUR OF DEATH

1-31-65

5:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1208 North Wolfe Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

7-8-05

9. AGE (In years last birthday)

59

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemp.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward Lyle

14. MOTHER'S MAIDEN NAME

Florence?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL SECURITY NO.

217-01-7811

17. INFORMANT

RECORDS: B.C.H. 4940 Eastern Avenue #21224

ADDRESS

18. 147 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Recurrent Carcinoma of Hypopharynx 1961
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-25 19 65 to 1-31 19 65, that (I) (we) last saw the deceased alive on 1-31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-31-65

23C. PHYSICIAN'S NAME (Type)

Dr. Richard Lane

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb 4 / 65

24C. NAME OF CEMETERY OR CREMATORY

Baldy Patch Cem

24D. LOCATION (City, town, or county) (State)

5301 Federal Ave. Balt. Md

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

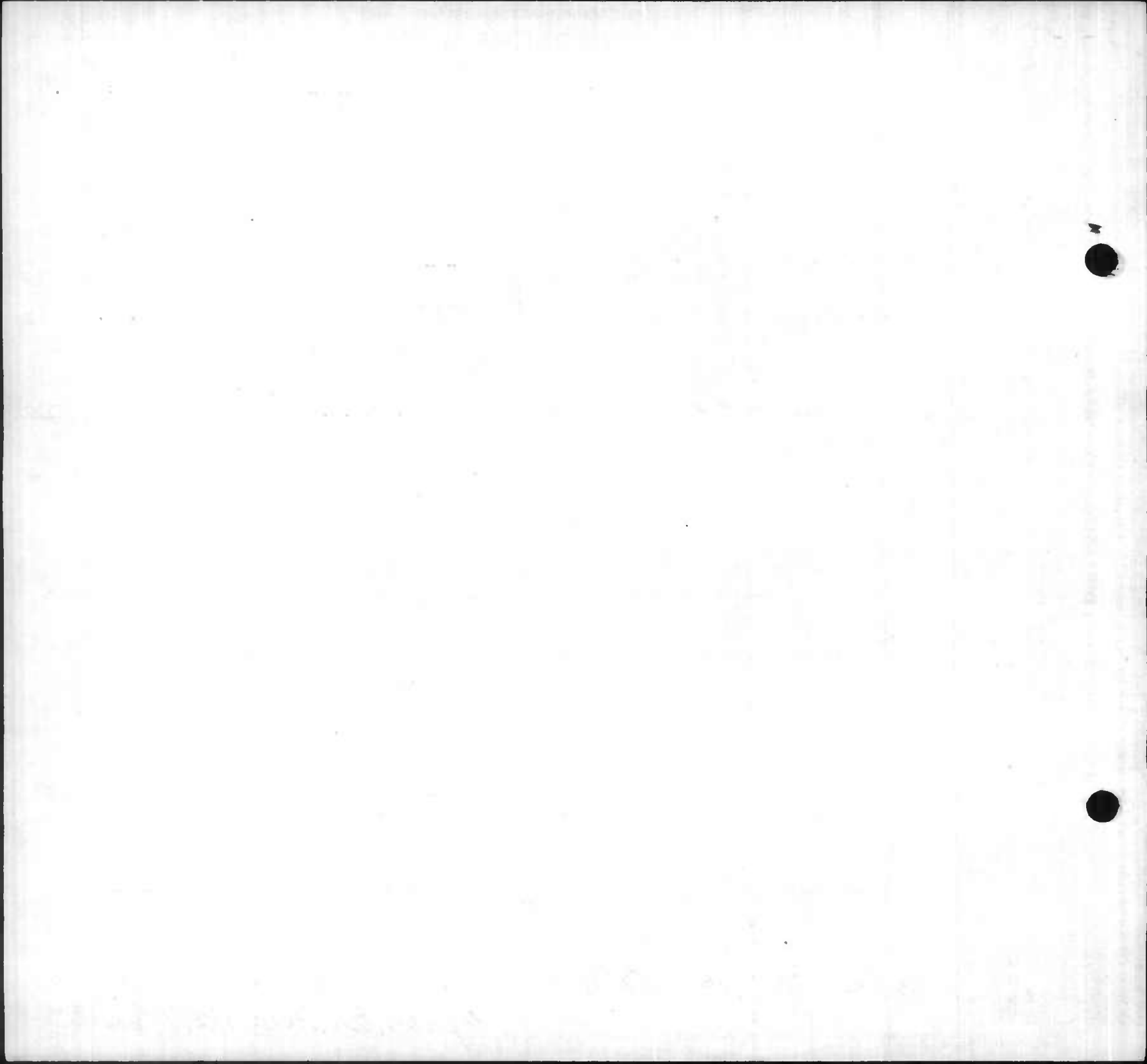
25C. FUNERAL DIRECTOR

John T. Eliskson 11297 Carver St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

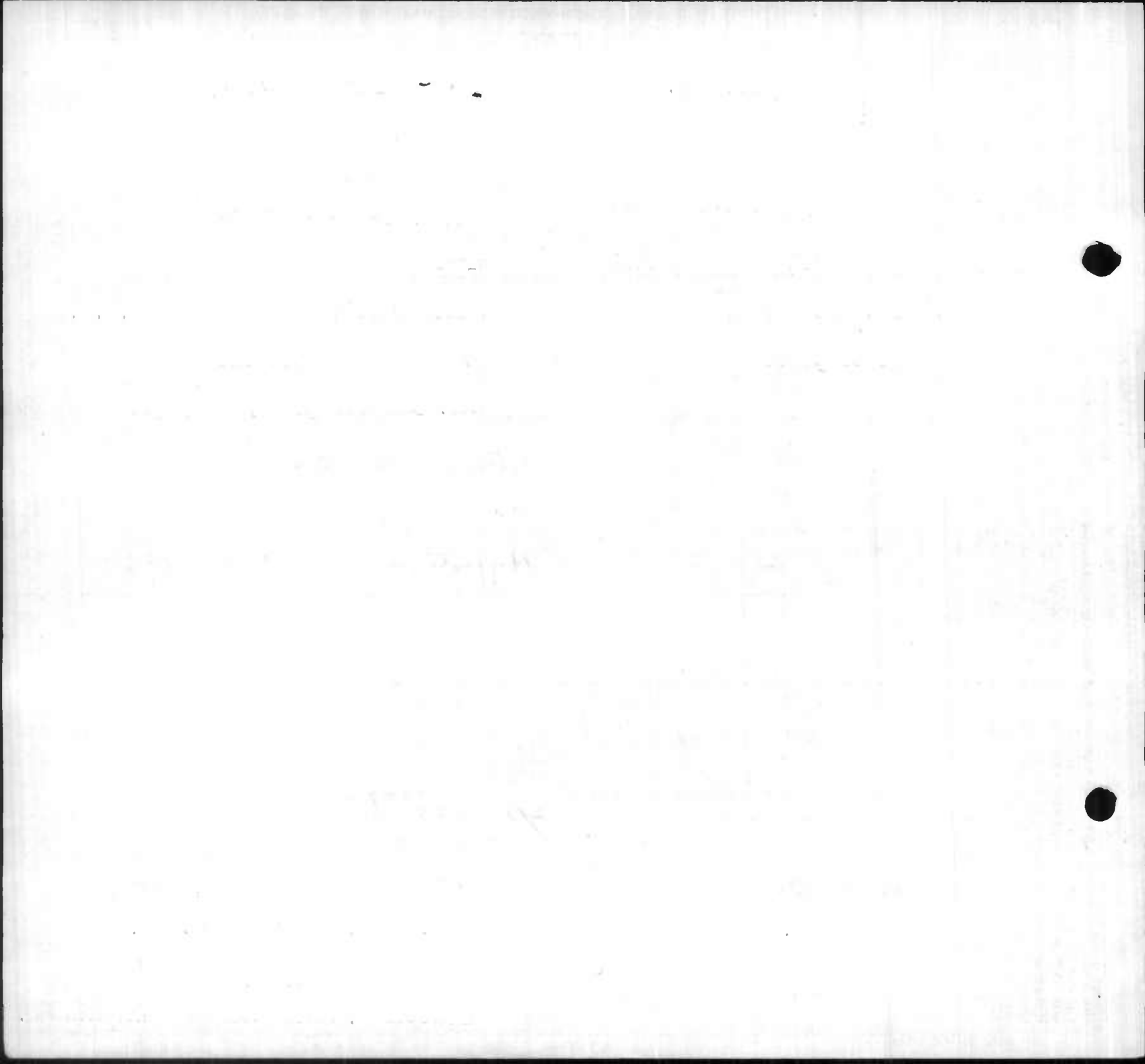
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

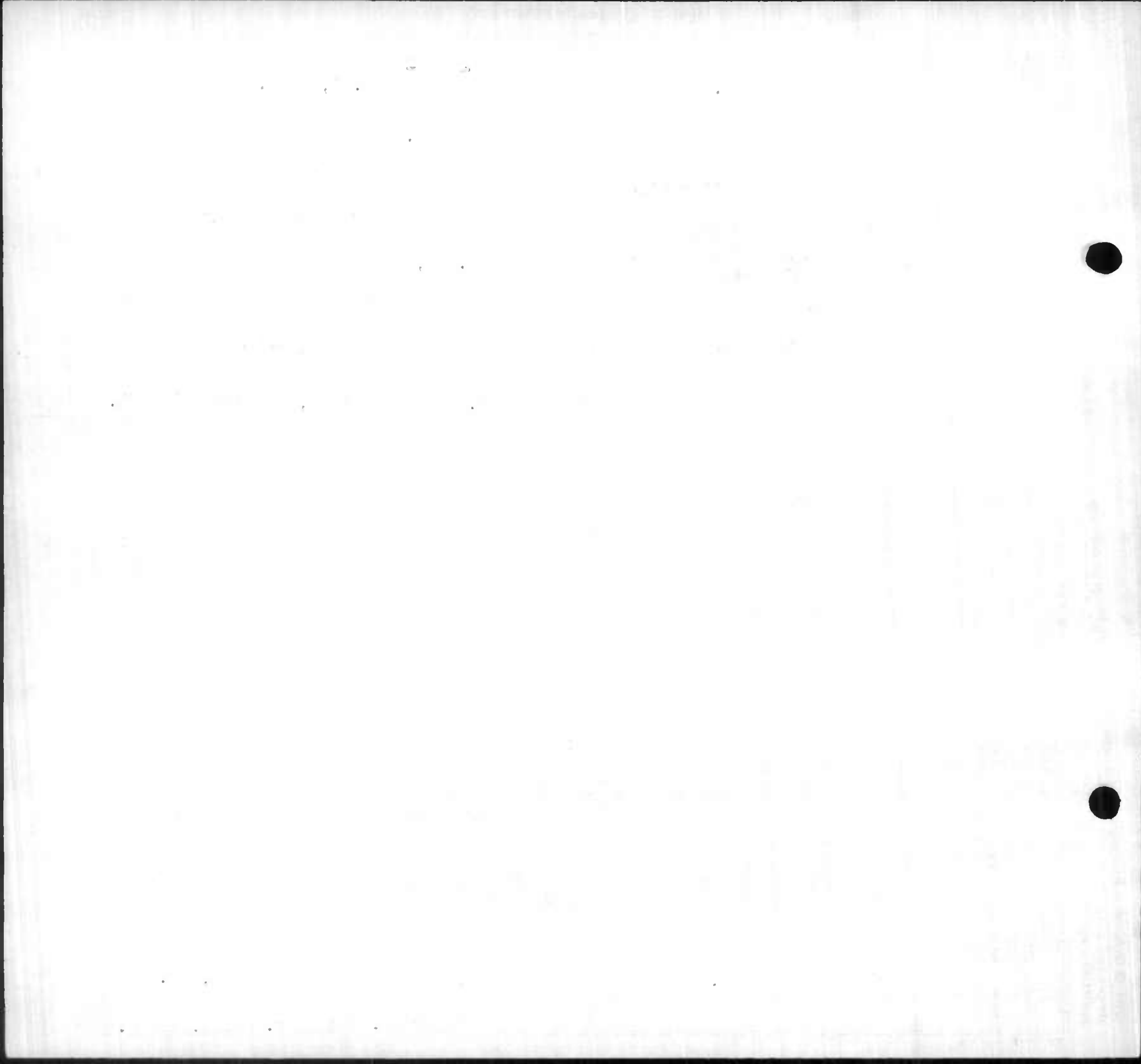
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | |
|--|-------------------------|---|---|---|--|---|---|-----------------------------------|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1223 | | | | | | | |
| BIRTH NO. 65 1223 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) John J. Enoch | | | | | 2. DATE AND HOUR OF DEATH February 1, 1965 11:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3704 Echodale Avenue | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3704 Echodale Avenue | | | | | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | | 8. DATE OF BIRTH 3-30-1899 | 9. AGE (In years last birthday) 65 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Type Writer Business | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Enoch | | | | | 14. MOTHER'S MAIDEN NAME ? Sheehan | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Frances Enoch, 3704 Echodale Ave | | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic CVD | | | | | CAUSE OF DEATH (A) Arteriosclerotic CVD DUE TO (B) Coronary occlusion DUE TO (C) Hypertension | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years 5 weeks 10 years | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1949 19 to 2/1 1965, that (I) (we) last saw the deceased alive on 2/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 23A. SIGNATURE W. H. Townshend | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 2/2/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Wilfred H. Townshend | | | | | 23D. ADDRESS M.D. 14 E. Eager Street - Balto. Md. 21202 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/4/65 | | 24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEMETERY | | | 24D. LOCATION (City, town, or county) (State) BALTO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc | | | ADDRESS 5305 Harford Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1224 | |
|--|---------|--|---|---|----------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1224 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Helen G. Delaney | | Feb. 1, 1965. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 811 Montpelier Street | | A. STATE Md. | | | |
| | | B. COUNTY 9-05 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore # 18 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 812 Homestead Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Female | White | Widow | Aug. 27, 1882 | 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | Own Home | Maryland | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William Powers | | | Catherine Fagan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | None | Mr. Samuel Dowling, 811 Montpelier St. # 18 | | |
| 18. 332 X I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Cerebral thrombosis | | | |
| | | (B) Arteriosclerosis | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 64 to Feb 1 19 65 , that (I) (we) last saw the deceased alive on January 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Robert E May | | | | 2/2/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| ROBERT E MAY M.D. | | 5662 The Alameda | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/4/65. | | New Cathedral Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 2 1965 | | Robert E. Farley, M.D. | | Leonard J. Ruck Inc. Balto. 14 Md. | |



C-423

65 1225

BALTIMORE CITY HEALTH DEPARTMENT

65 1225

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Philip
WILLIAM CHILCOATE

2. DATE AND HOUR PRONOUNCED DEAD

1-31-65

1:42 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

8710 Littlewood Road 21234

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 4, 1922

9. AGE (in years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Paint Thinner

10B. KIND OF BUSINESS OR INDUSTRY

O'Brien Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Philip J. Chilcoat

14. MOTHER'S MAIDEN NAME

Lillian Chenoweth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
213783810

17. INFORMANT

ADDRESS

Mrs. Kathleen M. Chilcoat

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/4/65

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 2 1965

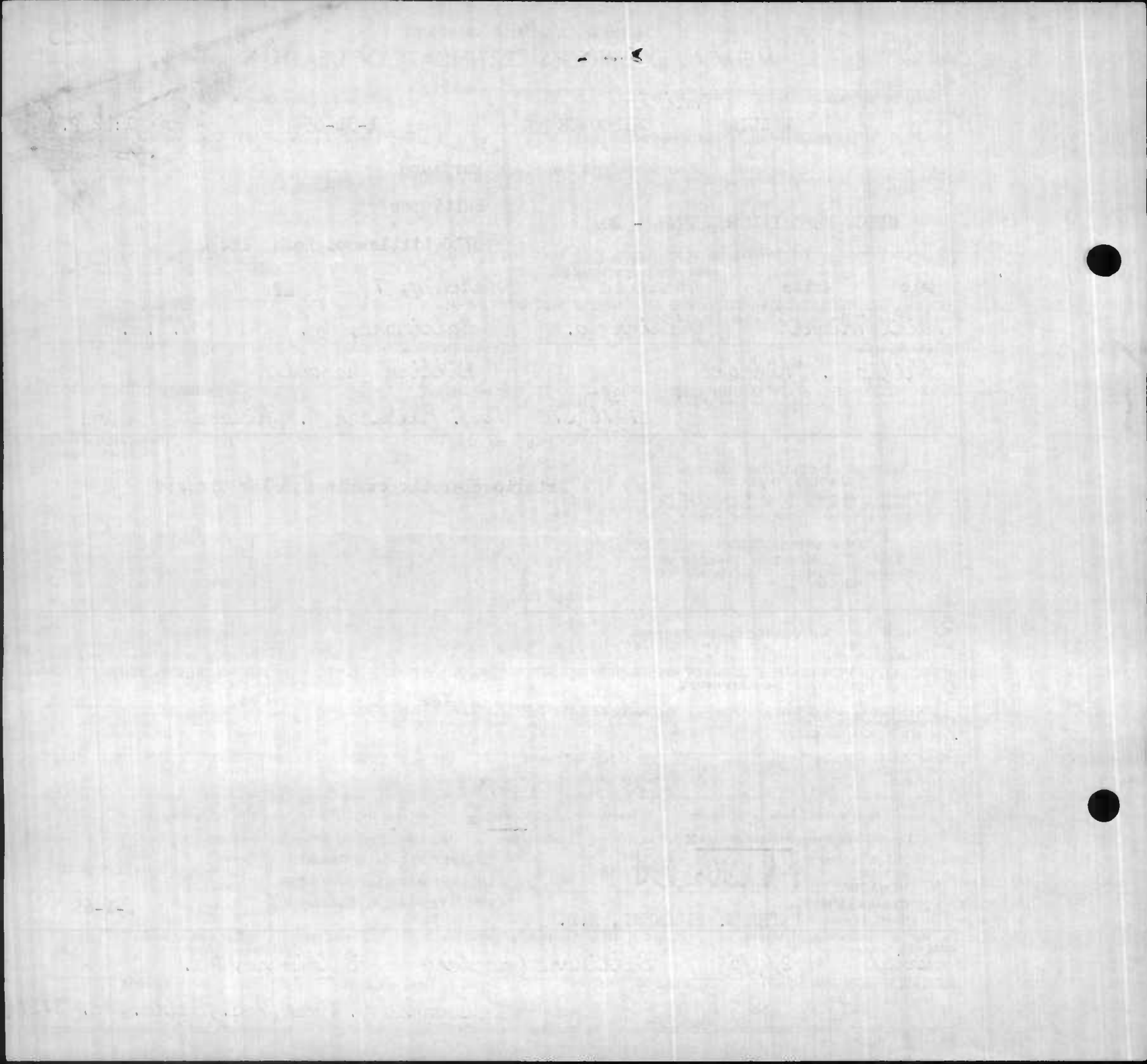
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., Balto., Md. 21214

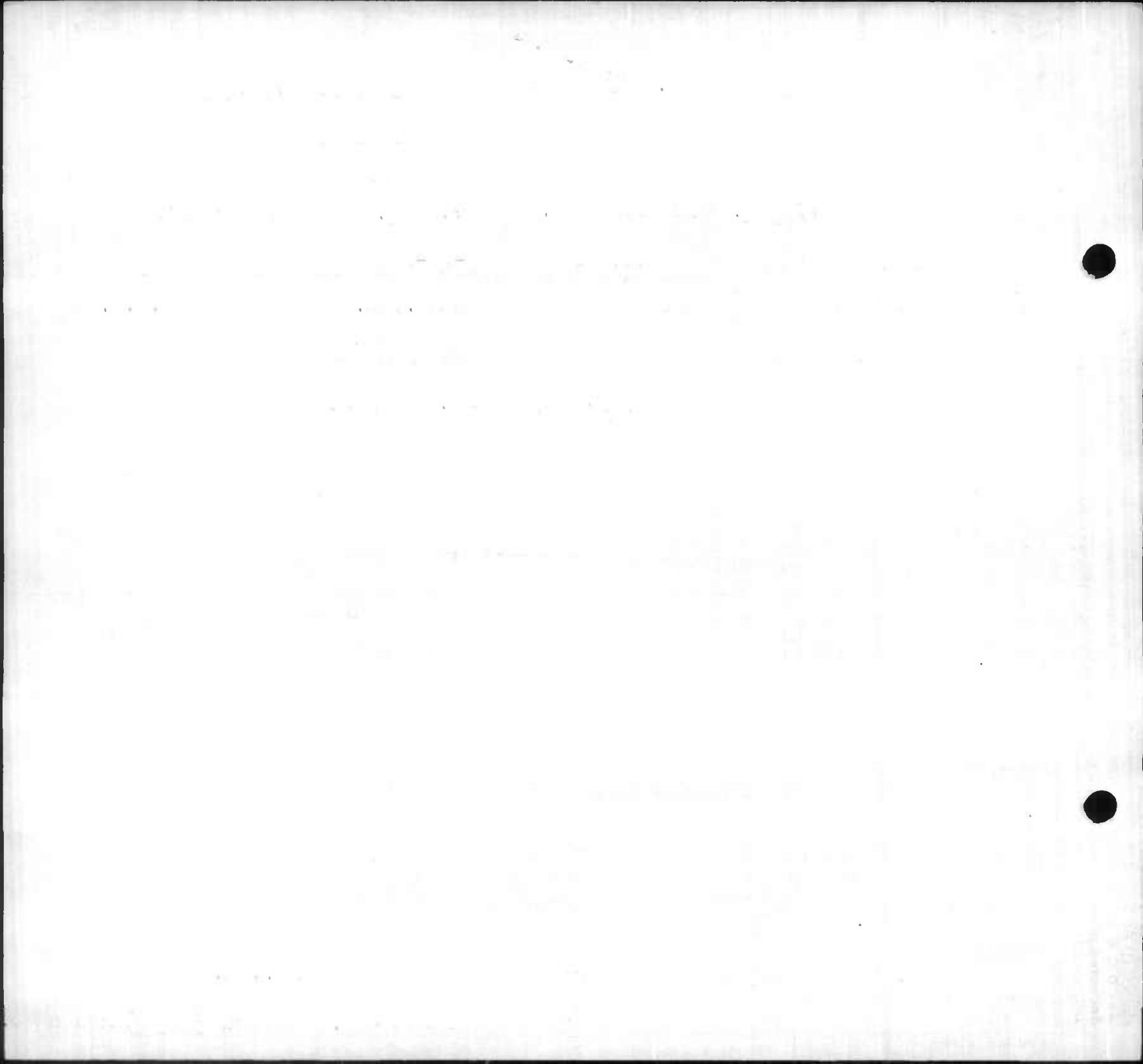
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1226 | |
|---|--|--|--|---|--|
| BIRTH NO. 65 1226 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Edwin H. Freeman | | | | February 1, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | |
| 1123 E. Belvedere Ave. | | 1123 E. Belvedere Avenue | | B. COUNTY 27-38 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | |
| 8. DATE OF BIRTH 9-15-1897 | | 9. AGE (In years last birthday) 67 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | |
| 11. BIRTHPLACE (State or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Freeman | |
| 14. MOTHER'S MAIDEN NAME Cora Gerding | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 705700297 | |
| 17. INFORMANT Mrs. Beulah Freeman | | ADDRESS same | | 18. 420.0 I | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Arteriosclerotic heart disease | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/31/60 19 to 2/1/65 19 that (I) (we) last saw the deceased alive on 12/5/64 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert E. May | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT E. MAY | | | | 23D. ADDRESS 5662 THE ALAMEDA | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/65 | | 24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery | |
| 24D. LOCATION (City, town, or county) Balto., Md. | | 24E. NAME OF REGISTRAR Robert E. May | | 24F. FUNERAL DIRECTOR Leonard J. Ruck Inc | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. May | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc | |
| 25D. ADDRESS 5305 Harford Rd. | | | | | |



1
M. 625

65 1227

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1227

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|--|---|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Bernard DENNIS MERSON | | | | 2. DATE AND HOUR PRONOUNCED DEAD 2-1-65 2:00 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1519 Medford Road 21218 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH March 16, 1944 | 9. AGE (in years last birthday) 20 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Roland B. Merson | | | | 14. MOTHER'S MAIDEN NAME Edna Holden | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 220-42-6807 | 17. INFORMANT Mr. Roland B. Merson | | ADDRESS Same | |
| 18. E812.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Blunt injury to chest with extensive laceration of right lung and massive hemothorax | | | | CAUSE OF DEATH | | | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mace Avenue - 300 ft. East of Stemmer's Run Road | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 2 1 '65 12:34 AM | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Passenger in auto striking guard rail | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE PETER W. KIECKERT, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 23B. DATE 2/4/65 | | 23C. NAME OF CEMETERY or CREMATORY Dulaney Valley Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. N875.2 FEB 2 1965 | | | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214 | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | | | |

MEDICAL CERTIFICATION

WALTER BOOTH

AND OTHERS

1894

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1228 | | | | CITY OF BALTIMORE HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1228 | |
|---|--|---|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Joseph James Erskine</i> | | 2. DATE AND HOUR OF DEATH <i>Feb 1, 1965 18:10 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Union Memorial Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-03</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| 5. SEX <i>Male</i> | | | | 6. RACE <i>Cauc</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Separated</i> | | 8. DATE OF BIRTH <i>4-19-1912</i> | |
| 9. AGE (In years last birthday) <i>52</i> | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>United States</i> | |
| 13. FATHER'S NAME <i>William H. Erskine</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Katherine Brogan</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes unknown</i> | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <i>Alfred H Erskine</i> | | 18. ADDRESS <i>415 Northgate Rd</i> | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>260x I</i> | | | | CAUSE OF DEATH (A) DUE TO <i>Intracerebral hemorrhage</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>right with rupture into ventricle</i> | | | | (B) DUE TO <i>atrial fibrillation</i> | | | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 29</i> 19 <i>65</i> to <i>Feb 1</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Feb 1</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Charles T. Fletcher</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Feb 1, 1965</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>CHARLES T. FLETCHER</i> | | | | 23D. ADDRESS <i>Union Memorial Hosp.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/4/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Balto. National</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i> | | ADDRESS | | | |

V.S. 153

2-5-65

M.H.

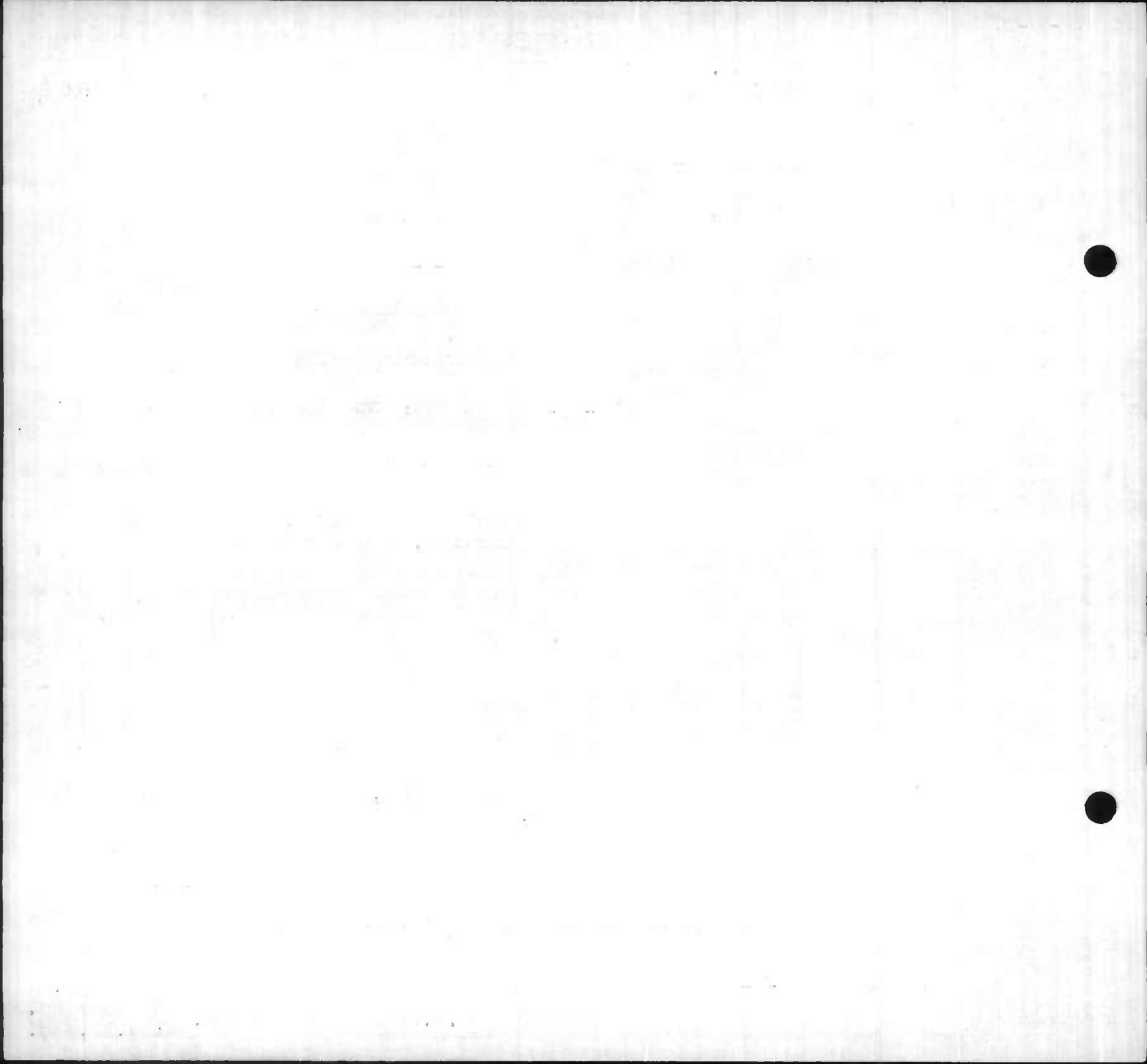
CHAS. E. FLETCHER

cdg: 42-57-701
M 23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

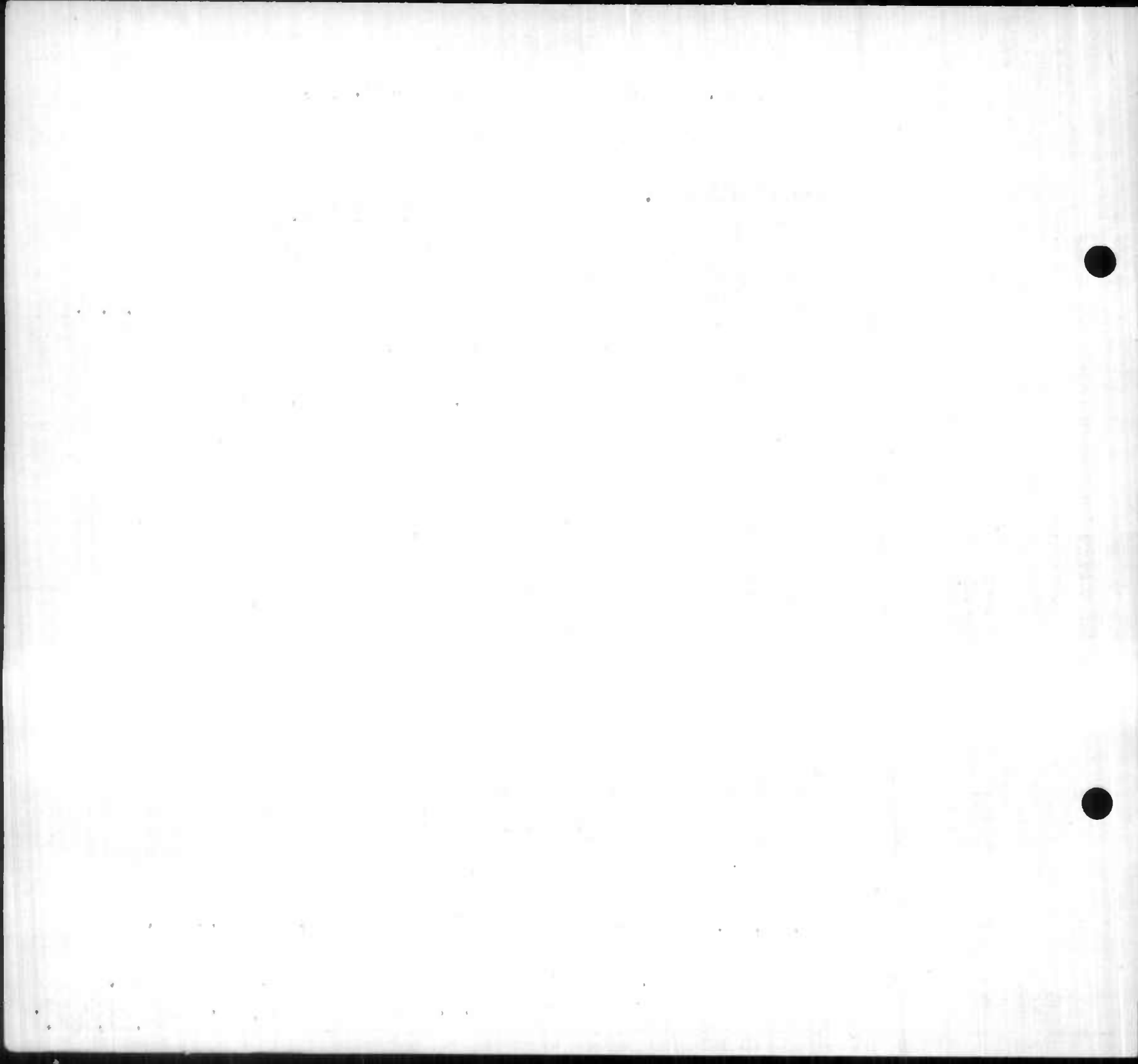
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1229 | |
|--|---------|--|------------------|--|--|--|------------------------------|
| BIRTH NO. 65 1229 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Nellie McDonald | | January 31, 1965 6:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3801 Ednor Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Female | White | Widowed | 12-3-86 | 78 | Laundress | Maryland | USA |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Peter Dunn | | | | Katherine Kelly | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 216-03-4449 | | RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | (A) Pulmonary Edema | | 8 days | |
| ANTECEDENT CAUSES | | | | (B) Congestive Heart Failure, Myocardial Infarction, Pulmonary Embolism | | 8 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 12, 1965 to January 31, 1965, that (I) (we) last saw the deceased alive on January 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Robert Cooke | | | | | | 1-31-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Robert Cooke | | | | 4940 Eastern Avenue 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2-4-65 | | New Cathedral | | Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| FEB 2 1965 | | Robert E. Jenkins, M.D. | | H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

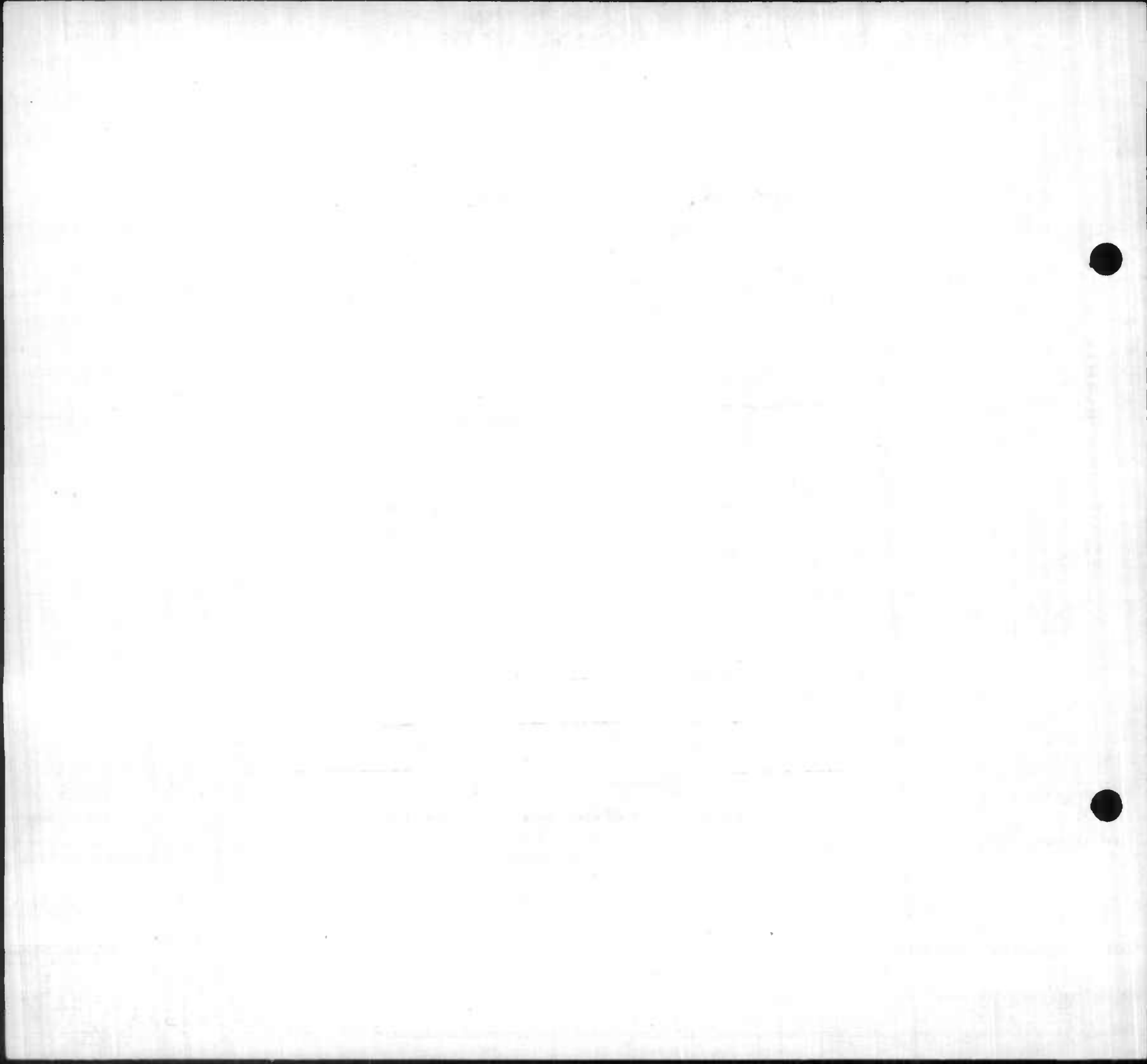
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---|--|---------------------------------------|---|---|
| BIRTH NO. 65 1230 | | CERTIFICATE OF DEATH | | 65 1230 | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Ethel M. Fisher | | Jan. 31, 1965 8:00 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 602 Nicoll Ave. | | A. STATE Maryland B. COUNTY 27-48 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 602 Nicoll Ave. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11/27/1883 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME David Henry Mullen | | 14. MOTHER'S MAIDEN NAME Susan Cramer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mrs. Elizabeth F. Strohecker (Same) | |
| 18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL ARTERY THROMBOSIS | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO ARTERIOSCLEROSIS | | 5 years | |
| | | (B) DUE TO Old age | | 5 years | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 10 1963 to Jan 31 1965 , that (I) (we) last saw the deceased alive on Jan 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A.S. Chalfant | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Feb 1 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. A. S. Chalfant | | 23D. ADDRESS 6210 York Road, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/3/65 | 24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery | | 24D. LOCATION (City, town, or county) (State) Govans, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | 25B. NAME OF REGISTRAR Robert E. Fisher | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1231 | |
|--|-----------|--|-------------------------------|---|--|--|--|
| BIRTH NO. 65 1231 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mary B. Zaetz | | 2. DATE AND HOUR OF DEATH January 29, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1200 Cooksie St. | | | | A. STATE B. COUNTY Maryland 2401 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1200 Cooksie St. | | | |
| 5. SEX T | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH May 10, 1896 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Austria | | 12. CITIZEN OF WHAT COUNTRY? Austria | |
| 13. FATHER'S NAME John Bohonos | | | | 14. MOTHER'S MAIDEN NAME Dzera | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ----- | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT ADDRESS Michael Zaetz 1200 Cooksie St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Coronary Occlusion | | Immediately | |
| ANTECEDENT CAUSES | | | | (A) DUE TO Hypertensive Cardiovascular Renal Disease | | About 10 Yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO ----- | | | |
| | | | | (C) ----- | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 ----- | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ----- | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ----- | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ----- | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ----- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ----- | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ----- | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? ----- | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 1954 to January 29, 1965, that (I) (we) last saw the deceased alive on January 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ernest G. Marr M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) ERNEST G. MARR, | | | | 23D. ADDRESS M.D. 516 CATHEDRAL ST., Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/2/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery | | 24D. LOCATION (City, town, or county) (State) Anne Arundel, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue | | | |



5-530

65 1232

BALTIMORE CITY HEALTH DEPARTMENT

65 1232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN W. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

1/29/65 10:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2300 blk. Etting St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2208 Linden Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

May 30, 1908

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

contractor

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Anna Mae Smith - 3772 W. Coldspring Ln.

18.

E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head and neck with
laceration of spinal cord, fracture
of skull and aspiration of blood

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2300 blk. Etting St.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 ? 65 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot in head and neck

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Werner N. Spitz
W.U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/29/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/4/65

23C. NAME OF CEMETERY or CREMATORY

Pleasant Rest

23D. LOCATION (City, town, or county)

Towson, Balto. Co. Md

24A. DATE REC'D BY HEALTH DEPT.

N879.2 FEB 3 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

W. L. Chatman Jr. - 1701 W. Cal
Baltimore, Md

ADDRESS

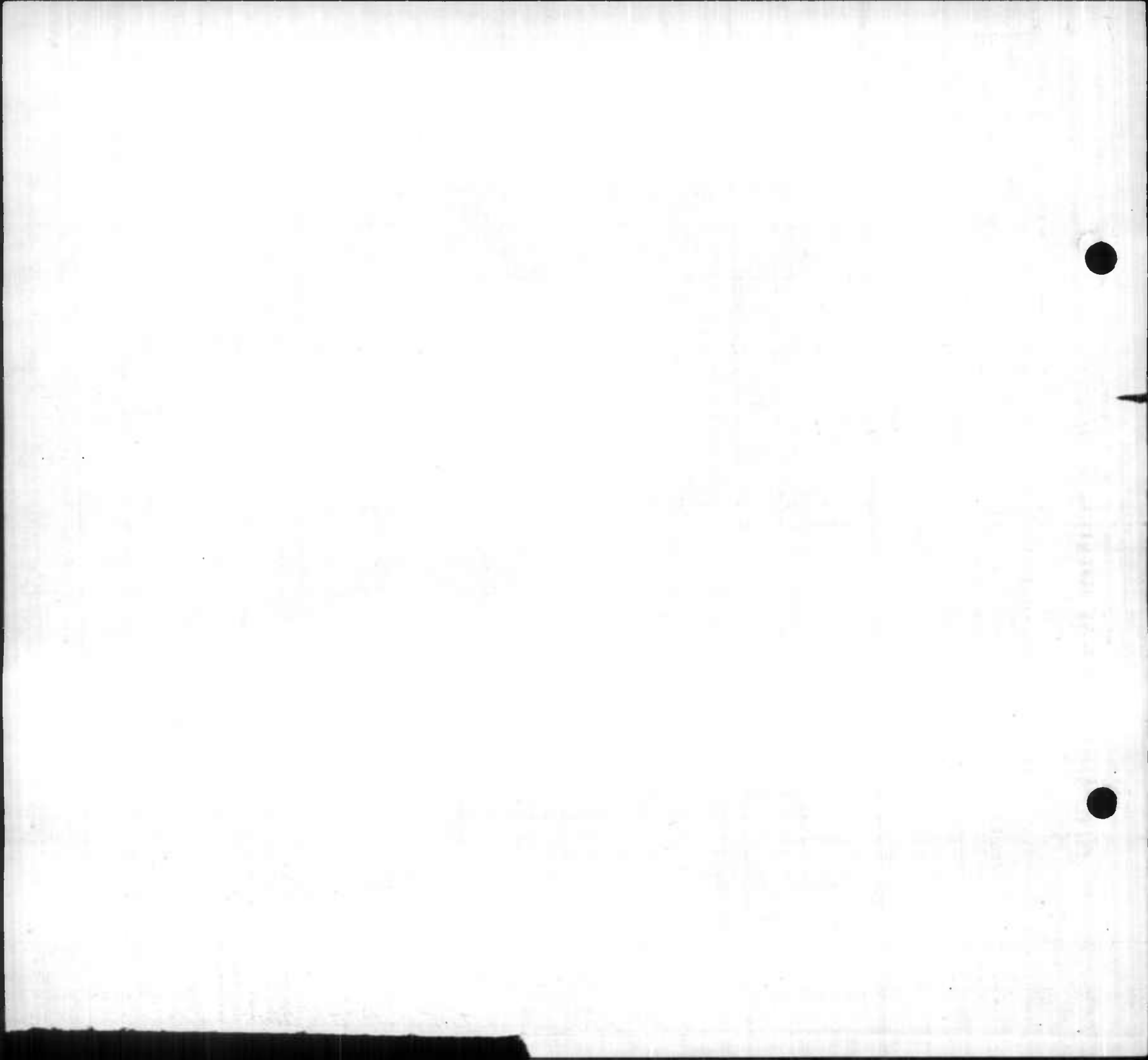
WALLEY POLICE

APR 2 1967

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

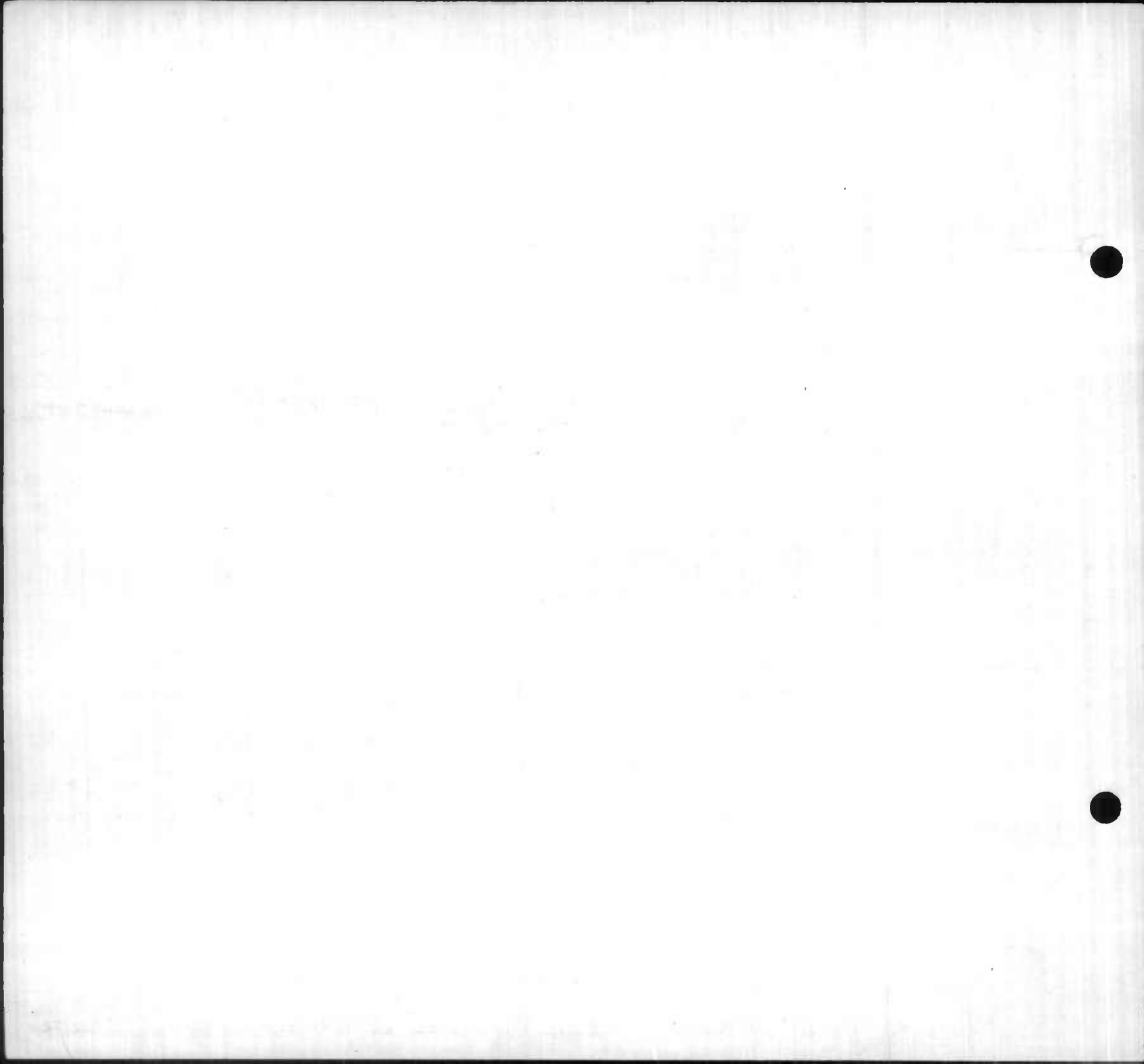
| | | | | | |
|--|------------------|--|-------------------------------------|---|--|
| BIRTH NO. 65 1233 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1233 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) TRAJE, ELARIO D. | | 2. DATE AND HOUR OF DEATH 1-31-65 1 8:35 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 203 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 31 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2043 Fleet St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 10-12-01 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Retired Marine | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Philippine Islands | |
| 13. FATHER'S NAME ANTONIO TRAJE | | 14. MOTHER'S MAIDEN NAME ARCADIA DELA ROSA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 086-16-4732 | | 17. INFORMANT ANNA DELAROSA the patient - 2043 FLEET ST | |
| 18. #43X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Constrictive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal Failure Hypertensive Cardiovascular Disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH few months few years years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-22-64 19 to 1-31-65 19, that (I) (we) last saw the deceased alive on 1-31-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cesar R. Bariso | | | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) CESAR R. BARISO | | 23D. ADDRESS Church Home & Hosp., Baltimore 4, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE FEB 3 65 | | 24C. NAME OF CEMETERY or CREMATORY ST PAUL CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BOSTON STREET MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, MD | | 25C. FUNERAL DIRECTOR THE HOPKINS BRAS & CO. FLOWERS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------|---|-----------------------------------|---|--|---|--|------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1234 | | | | |
| BIRTH NO. 65 1234 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) FLORENCE A. GARRISON | | | | | 2. DATE AND HOUR OF DEATH 1/30/65 645 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | | A. STATE MD B. COUNTY BALT. | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. | | | | |
| D. STREET ADDRESS (If rural, give location) 3021 ROSALIND AVE | | | | | | | | | |
| 5. SEX FEM | 6. RACE WT | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIV. | | 8. DATE OF BIRTH 4/9/95 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT SHERMAN K. GARRISON | | | | |
| | | | | | ADDRESS 3641 ELM | | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) ARTERIOSCHLEROTIC DUE TO CARDIO-VASCULAR DISEASE (B) DUE TO (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/2/65 19 65 to 1/30 19 65, that (I) (we) last saw the deceased alive on 1/30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Harvey A. Levin | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-3-65 | | 24C. NAME of CEMETERY or CREMATORY LORRAINE PARK | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR Paul E. Chenoweth | | | ADDRESS 3617 Chemt ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1235

BIRTH NO. 65 1235

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARTIN WILLIAM MC FADDEN

2. DATE AND HOUR OF DEATH

Jan. 31, 1965, 8:05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

US Public Health Service Hospital
Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

206 S. Norris Street

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7/13/07

9. AGE (In years)

lost birthday 57

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance man

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Mc Fadden

14. MOTHER'S MAIDEN NAME

Emily Cell

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

USA (dates ?)

16. SOCIAL SECURITY NO.

565 16 8264

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18. 135.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardiac arrest
DUE TO

Terminal

(B) Hyperpotassemia
DUE TO

Days

(C) Carcinoma of the liver

1 mo.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hepato-renal syndrome

Days

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 19 1965 to Jan. 31 1965, that (I) (we) last saw the deceased alive on Jan. 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James H. Frank

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2/1/65

23C. PHYSICIAN'S NAME (Type)

James H. Frank, Surgeon (R)

23D. ADDRESS

M.D. US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb. 3, 1965

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cem.

24D. LOCATION (City, town, or county) (State)

Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 3 1965

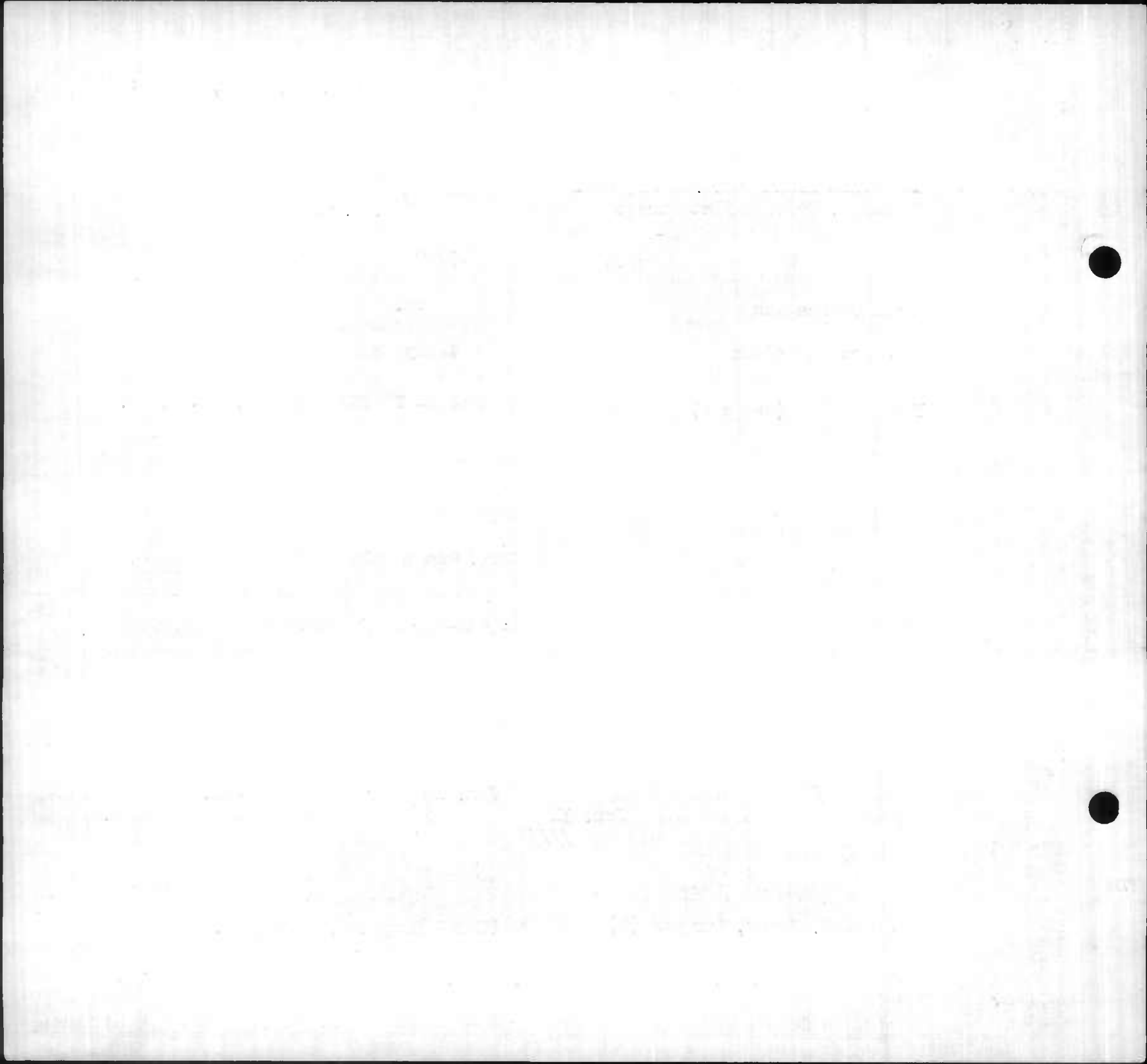
25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Walters, Funr. Home Pratt & Stricker

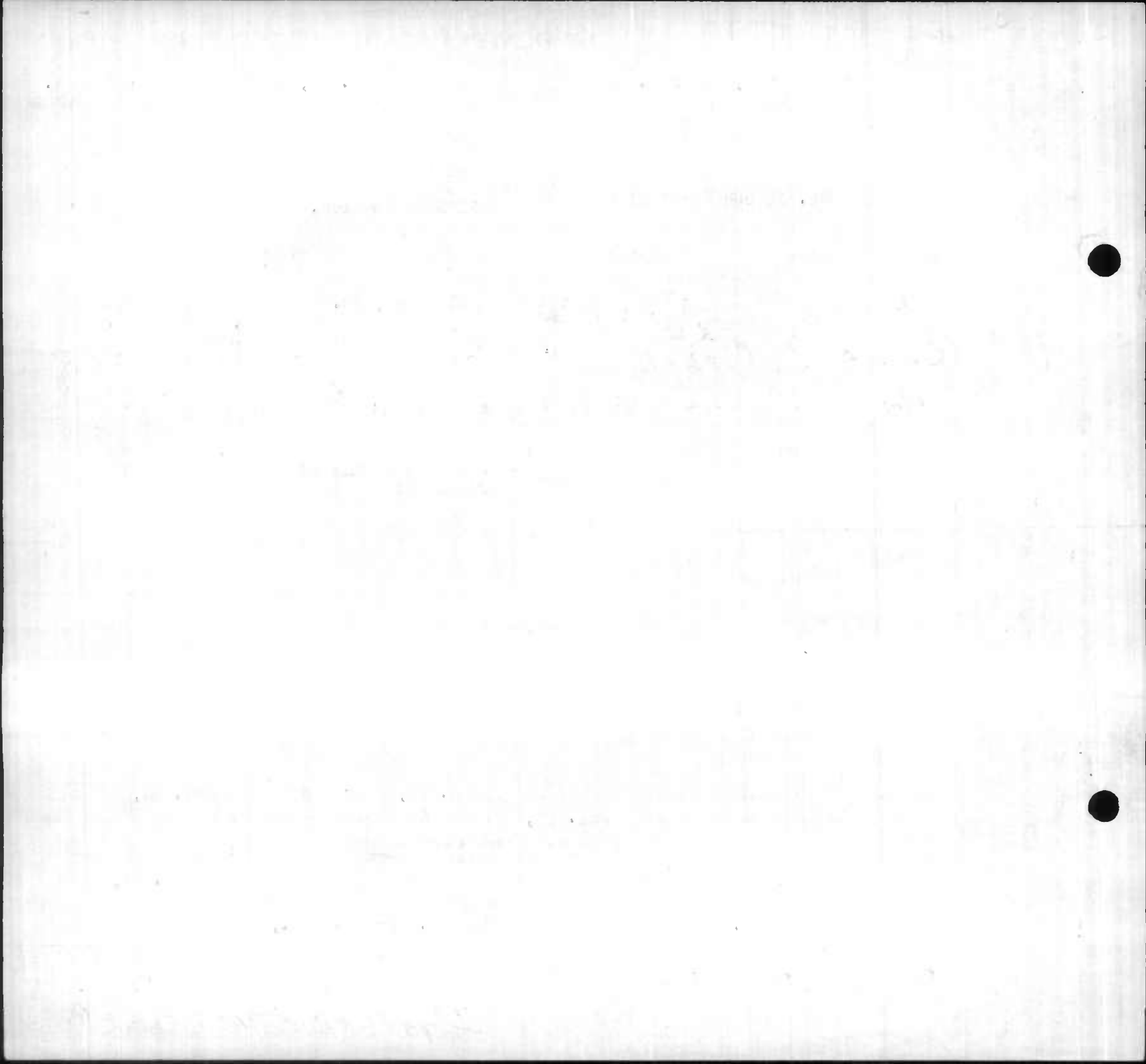
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|-----------------------------------|--|--|--|---|--|-----------------------------|--|--|---|--|--|--|--|
| BIRTH NO. 65 1236 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1236 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baker, James C. SR | | | | | 2. DATE AND HOUR OF DEATH Jan. 31, 1965 7:55 A.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2603 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6 D. STREET ADDRESS (If rural, give location) 3125 Dudley Ave. | | | | | | | | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 5/2/86 | | 9. AGE (In years last birthday) 78 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE | | | | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME JAMES C. BAKER | | | | | 14. MOTHER'S MAIDEN NAME SARAH JANE NEIMEYER | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 220-44-1452 | | | | | 17. INFORMANT L. WARD BAKER 6028 ALTA AVE | | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute cholecystitis with peritonitis | | | | | | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery disease | | | | | | | | | | | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 21A. DATE OF OPERATION | | | | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 22A. AUTOPSY? (Yes or No) No | | | | | 22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 24D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 24E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 24F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 25. I certify that (I) (this hospital) attended the deceased from Jan. 29, 1965 to Jan. 31, 1965 , that (I) (we) last saw the deceased alive on Jan. 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Juan Gan | | | | | | | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED Jan. 31, 1965 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Juan G. Gan | | | | | | | | | | M.D. 1400 N. Caroline St., 21213 | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 2-3-65 | | | | | 24C. NAME of CEMETERY or CREMATORY LONDON PARK CEM. | | | | | 24D. LOCATION (City, town, or county) (State) FEDERICK Rd BALTO MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | | | | 25C. FUNERAL DIRECTOR DIPPEL BROS 7110 BELAIR ROAD | | | | | ADDRESS | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

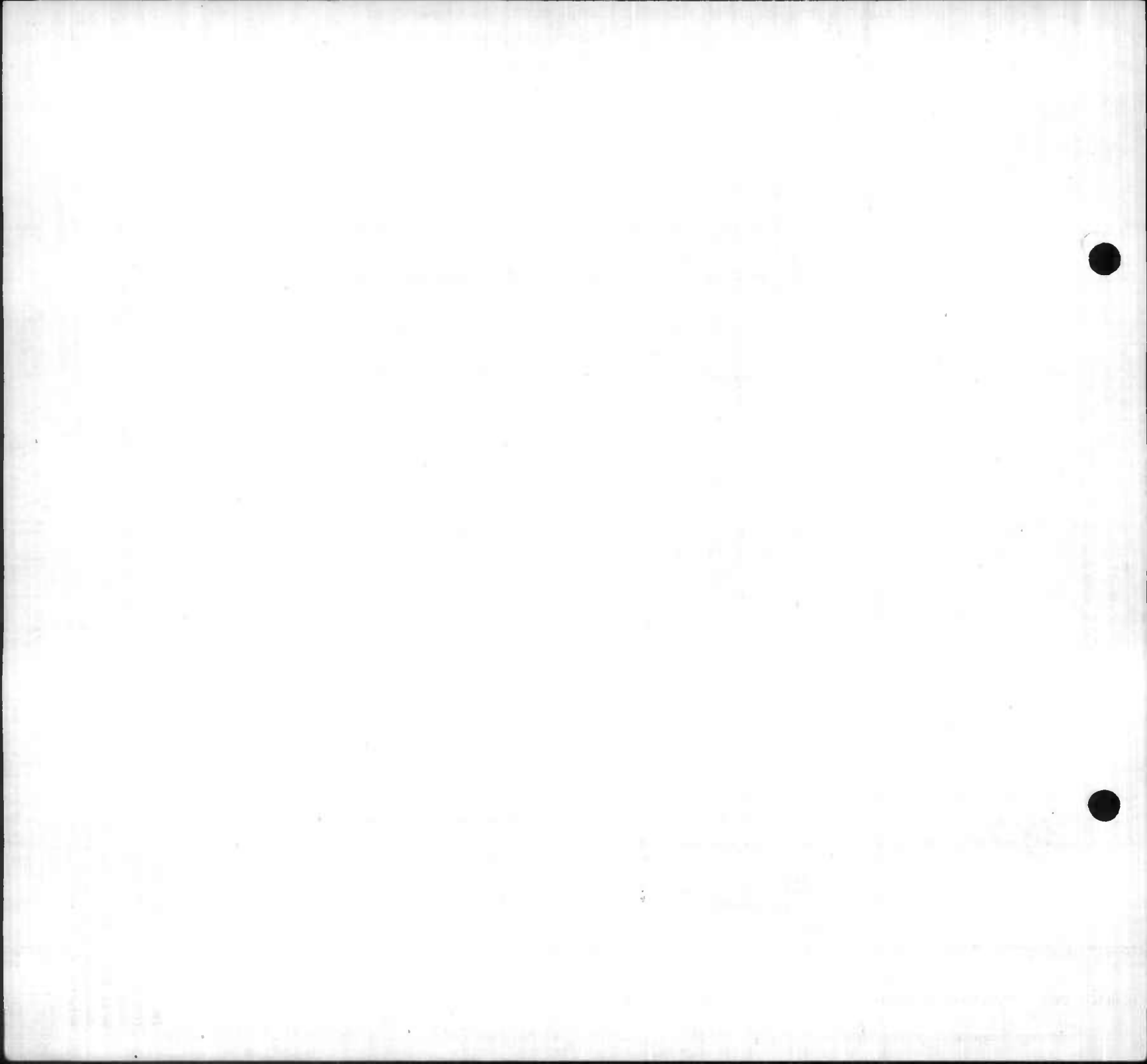
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1237 | |
|--|------------------|---|--|---|---|
| BIRTH NO. 65 1237 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Mr. Henry Beardon McNally Jr. | | | | 2/1/65 12:50 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital | | | | A. STATE Maryland B. COUNTY 27-11 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12, Md | | | | D. STREET ADDRESS (If rural, give location) 401 Woodford Road | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10/14/04 | 9. AGE (In years last birthday) 60 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Tech. |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Henry Beardon McNally sr. | | | 14. MOTHER'S MAIDEN NAME Justine Jamet | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) National Guard | | | 16. SOCIAL SECURITY NO. 214-03-3413 | | |
| 17. INFORMANT Wife | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I CAUSE OF DEATH Cardiac Arrest 2° Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 1/31/65 → 2/1/65 | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary art. sclerosis, severe with occlusion of left anterior branch, recent. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 1/31/1965 to 2/1/1965, that (we) last saw the deceased alive on 2/1/1965 and that in (our) opinion death occurred on the date and hour end from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William B. Long | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM B. LONG | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-1965 | | 24C. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Towson, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Baltimore, Md. | | | |

ALL A L R

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

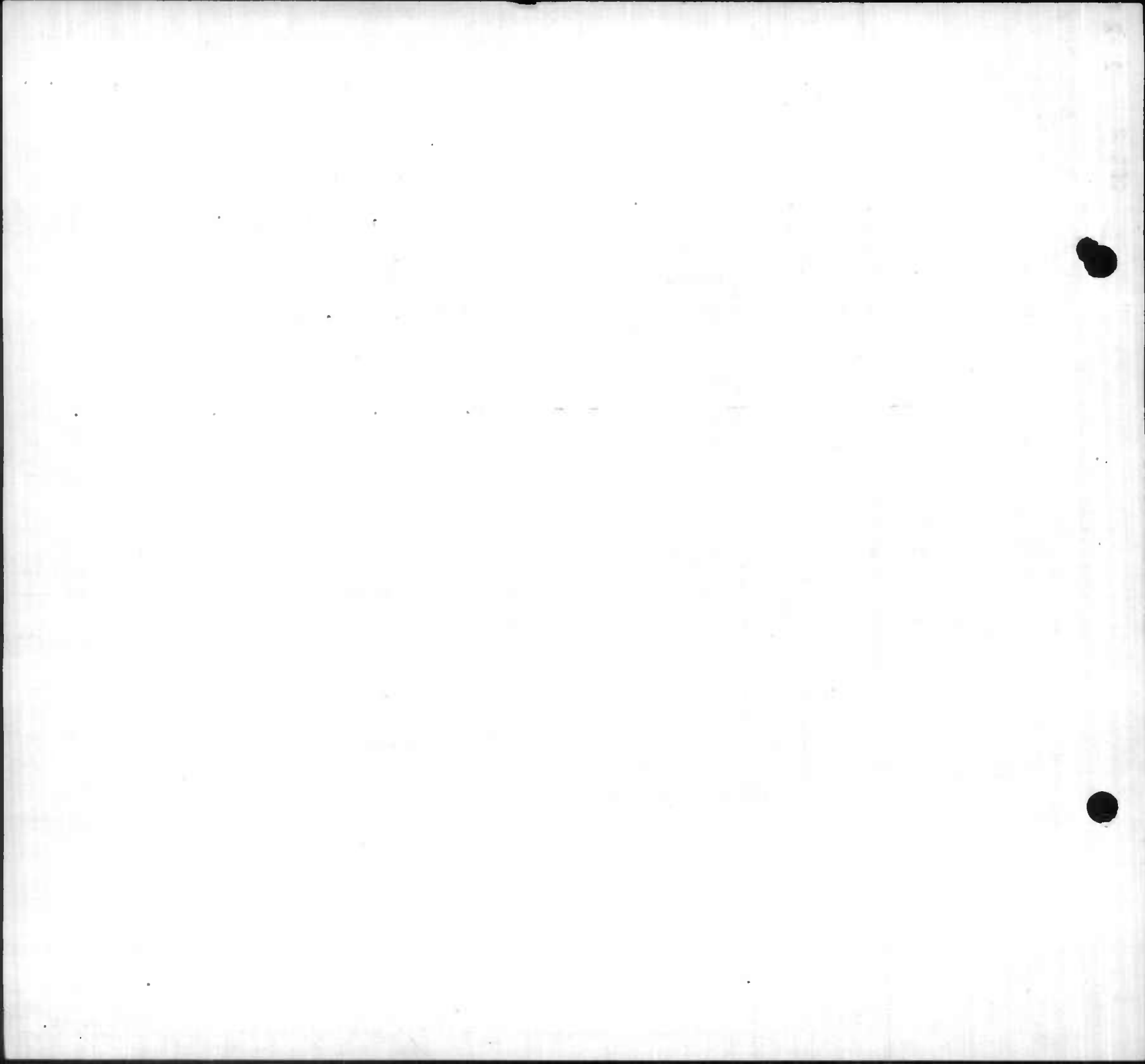
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1238 | |
|--|------------------------------|--|--|--|---|
| BIRTH NO. 65 1238 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN JOSEPH ANZENGRUBER | | 2. DATE AND HOUR OF DEATH 1-29-65 9 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MO. B. COUNTY Balto | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION HOME FOR THE AGED 90 LITTLE SISTERS OF THE POOR 1200 VALLEY STREET | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 4038 Blucher Rd. | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH JUNE 30, 1869 | 9. AGE (In years last birthday) 95 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME MATHIES ANZENGRUBER | | 14. MOTHER'S MAIDEN NAME MARY C. SCHALOT | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-01-2997F1 | | 17. INFORMANT LITTLE SISTERS OF THE POOR | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I Pulmonary edema | | CAUSE OF DEATH (A) DUE TO G. S. C. V. D. (B) DUE TO Old age (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to Jan 20, 1965 , that (I) (we) last saw the deceased alive on Jan 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley Ankudas | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2.1.65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. STANLEY ANKUDAS | | 23D. ADDRESS M.D. 1802 W. BALTIMORE ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/1/1965 | 24C. NAME OF CEMETERY or CREMATORY Fork Methodist Church Cemetery | | 24D. LOCATION (City, town, or county) (State) Fork, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR John A. Moran Inc 3000 E. Baltimore St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

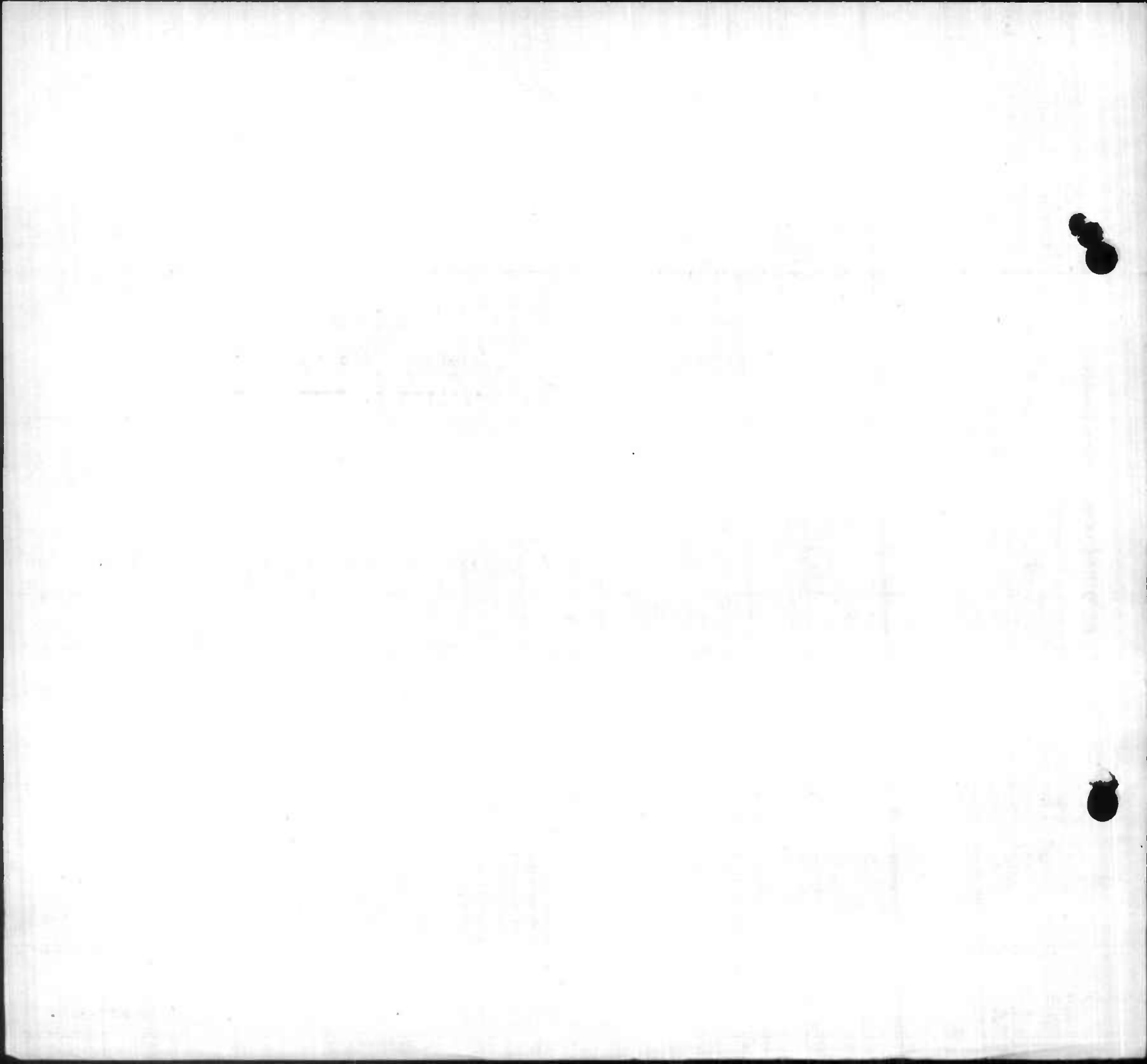
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1239 | |
|--|---------------|--|--------------------------|---|----------------------------|--|--|
| BIRTH NO. 65 1239 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN BAKER | | 2. DATE AND HOUR OF DEATH 2-1-65 11,32 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL. | | | | A. STATE MARYLAND B. COUNTY 7-03 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 5 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2305 E. MADISON ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH 1-26-85 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME GEORGE BAKER | | | | 14. MOTHER'S MAIDEN NAME CATHERINE FUNTE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -- -- | | 16. SOCIAL SECURITY NO. 215-01-7106 | | 17. INFORMANT ADDRESS Mr. John H. Baker 2305 E. Madison St. 5 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Acute Myocardial infection (B) ASCVD (C) | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemorrhagic Cystitis | | | | | | ~ 3 days. | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/21 1965 to 2/1 1965, that (I) (we) last saw the deceased alive on 2/1 11:32 P.M. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jerry L. Spivack M.D. | | | | 23B. DATE SIGNED 2/2/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Jerry L. Spivack M.D. | | | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Feb. 5/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore d. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Philip Newig Sons | | ADDRESS 2024 Orleans St. 31 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

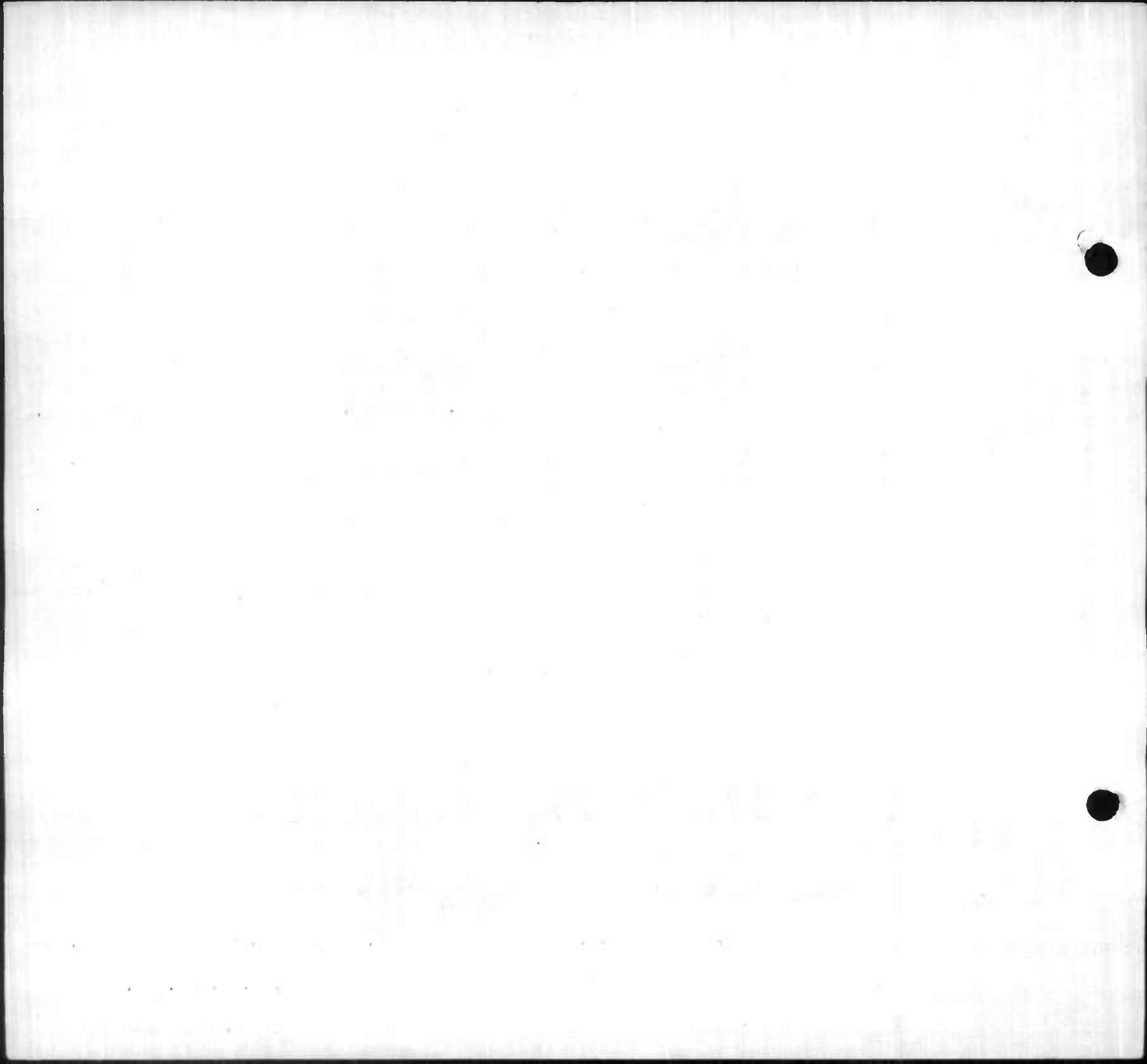
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1240 | |
|--|-----------|--|--------------------------|--|--|
| BIRTH NO. 65 1240 | | CERTIFICATE OF DEATH | | Registered No. 65 1240 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) DONALDSON, BERTHA | | 2. DATE AND HOUR OF DEATH 1-31-65 725 PM 725 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Md B. COUNTY 28-04 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| Bon Secours Hospital | | Baltimore | | 4803 Edmondson Ave | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 12-6-87 | 9. AGE (In years last birthday) 77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George Deinlein | | 14. MOTHER'S/MAIDEN NAME Mary Doetzer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT William P. Webb Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Ventricular fibrillation DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes | |
| ANTECEDENT CAUSES | | (B) Congestive heart failure DUE TO | | 2 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Arteriosclerotic Heart Disease | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (he) (this hospital) attended the deceased from JAN 29 19 65 to JAN 31 19 65, that (he) (we) last saw the deceased alive on JAN 31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Licuanan | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED FEB 1, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) JESUS L. LICUANAN M.D. | | 23D. ADDRESS BON SECOURS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Fred A. Cole 1913 W. Baltimore St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>65 1241</u> | |
|---|-------------------------|---|--------------------------------------|--|---|---|--|
| BIRTH NO. <u>65 1241</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Happy M. Meyers.</u> | | 2. DATE AND HOUR OF DEATH <u>Feb 2, 1965</u> <u>5:30 P. M.</u> | |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>24-04</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hosp.</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | D. STREET ADDRESS (If rural, give location) <u>232 E. Barney St.</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | B. DATE OF BIRTH <u>7-25-1888</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Die Setter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Metal</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Meyers.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sophia Stricker</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Louise B. Calvert</u> | | ADDRESS <u>526 Cedar Hill Ave.</u> | |
| 18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertensive Arteriosclerotic Vascular Disease</u> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from <u>12-22</u> 19 <u>64</u> to <u>2-1</u> 19 <u>65</u> , that the (we) last saw the deceased alive on <u>2-1</u> 19 <u>65</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Sigmund A. Amitin</u> | | | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2-2-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>SIGMUND A. AMITIN, M.D.</u> | | | | 23D. ADDRESS <u>South Balto. Gen. Hosp. - 1213 Light St.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2 5 65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u> | | 24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 3 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Mc Cully</u> | | ADDRESS <u>130 E. Fort Ave</u> | |



B-500

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO. 65 1242
M.E. CASE NO. 20899

65 1242

| | | | | | | | |
|--|-------------------------|---|--------------------------------------|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) Babe VICTORIA BOWEN | | | | 2. DATE AND HOUR PRONOUNCED DEAD 2-1-65 11:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 2-18-65 2573 MARBOURNE AVENUE | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2573 Marbourne Avenue 21230 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 7/31/1964 | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 6 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTO. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME William E. Bowen | | | | 14. MOTHER'S MAIDEN NAME Ruth E. Gerden | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT 2573 MARBOURNE AVE. (30) MR. WILLIAM E. BOWEN | | | |
| 18. 500X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH Laryngitis, tracheitis and bronchitis, acute Interstitial pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO (B) DUE TO (C) DUE TO | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE m. WORK AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. S. Fisher CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-1-65 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 2/3/1965 | | 23C. NAME of CEMETERY or CREMATORY Lakeview Cem. | | 23D. LOCATION (City, town, or county) (State) RANDALLSTOWN Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS GI. TRUMAN Schwab 3512 FREDERICK AVE. (29) | | | |

Letter from M.E.'s Office

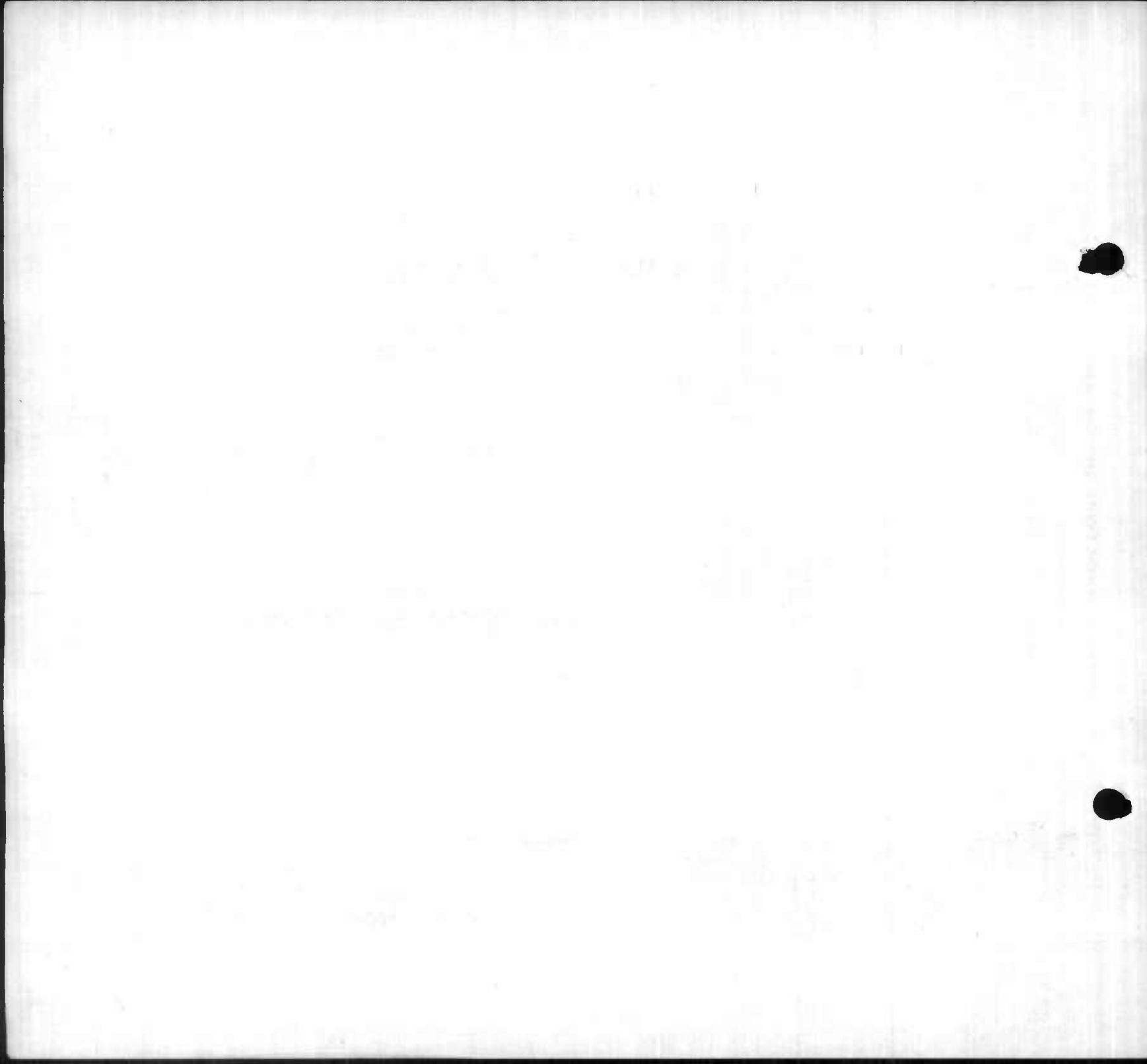
2-13-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

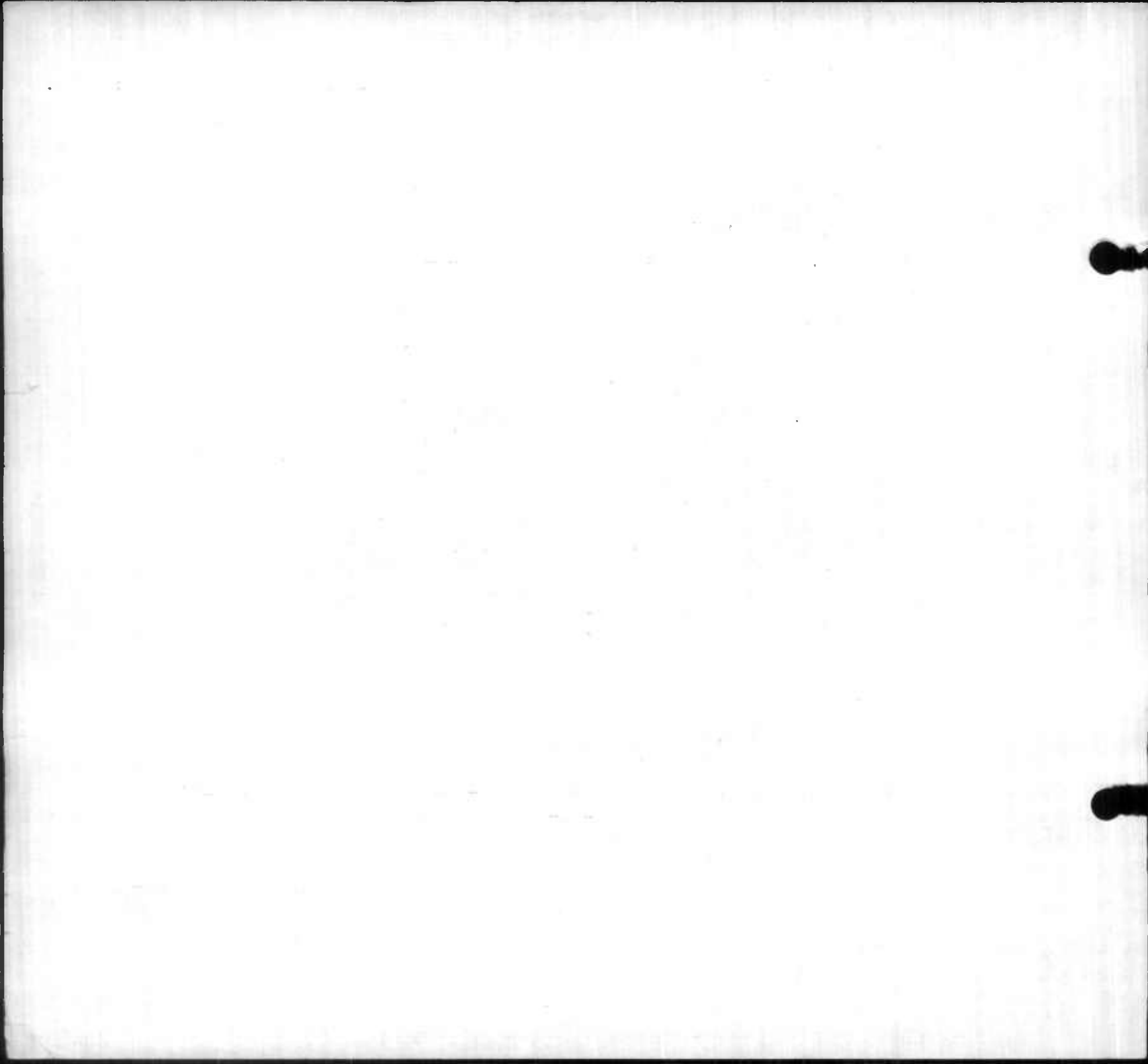
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|--|-------------------------------------|--|--|--|--|--|------------------------------|--|--|---|--|--|--|--|
| BIRTH NO. 65 1243 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1243 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES OWENS | | | | | | | | | | 2/1/65 11:35 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | | | | | | A. STATE MARYLAND | | | | | | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 31 | | | | | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 205 S. BETHEL ST | | | | | | | | | |
| 5. SEX M | | 6. RACE N | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 10-31-14 | | 9. AGE (In years last birthday) 50 | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | | | | | |
| Self Employed | | | | | | | | | | Balto Md | | | | | | | | | |
| 13. FATHER'S NAME WILLIAM Owens | | | | | 14. MOTHER'S MAIDEN NAME MARY KEYS | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Beatrice Owens | | | | | | | | | |
| | | | | | | | | | | ADDRESS Same | | | | | | | | | |
| 18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Sigmoid Colon | | | | | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 moo p onset of abd. pain | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | HEPATIC METASTASES | | | | | | | | | |
| 19A. DATE OF OPERATION 12-23-64 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA | | | | | 20A. AUTOPSY? (Yes or No) NO | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (this hospital) attended the deceased from 12-8-1964 to 2-1-65 19 65 , that (we) last saw the deceased alive on 2-1-1965 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE A. Douglas Logue | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 2-2-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) A. DOUGLAS LOGUE | | | | | | | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 2-4-1965 | | | | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cml | | | | | 24D. LOCATION (City, town, or county) (State) Brooklyn Md | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | | | | 25C. FUNERAL DIRECTOR Choy, W. Blair W. Beatty Jr. | | | | | ADDRESS | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

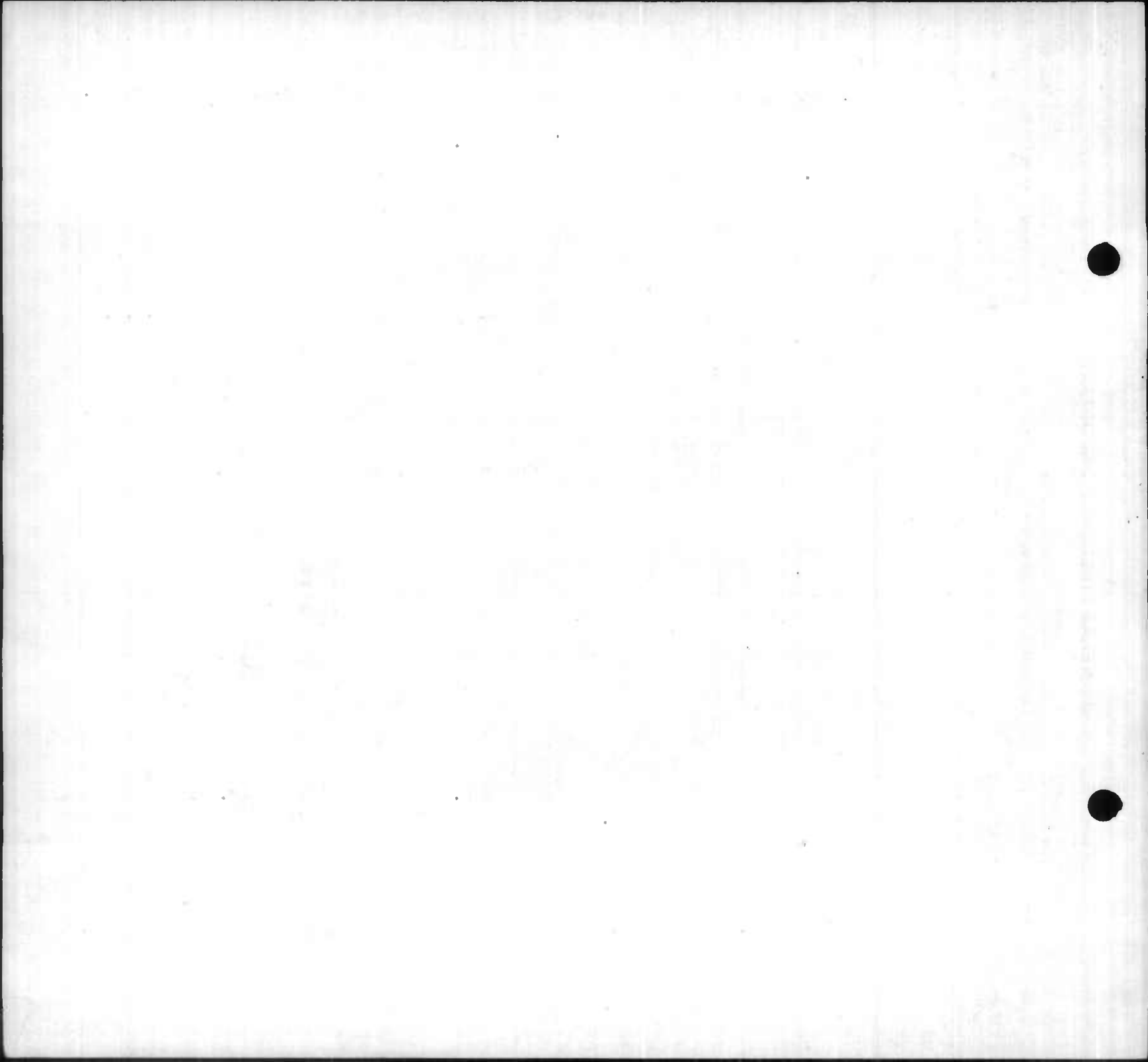
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1244 | |
|--|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. 65 1244 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>William Hurd</u> | | | 2. DATE AND HOUR OF DEATH <u>1-31-65</u> <u>6:30</u> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1326 Edmondson Avenue</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>2-8-24</u> | 9. AGE (In years last birthday) <u>40</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>Daniel Hurd</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Leah Johnson</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>William Hurd son 2246 Booth St</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Paralytic Ileus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute hemorrhagic pancreatitis</u> <u>Chronic alcoholism</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u> <u>1. Marked fatty metamorphosis of liver</u> <u>2. Marked hemorrhage and edema of both lungs</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-30-65</u> 19 to <u>1-31-65</u> 19, that (I) (we) last saw the deceased alive on <u>1-31-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Hollis Seunarine, M.D.</u> | | | 23B. DATE SIGNED <u>2-1-65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Hollis Seunarine</u> | | | 23D. ADDRESS M.D. <u>1514 Division Street</u> | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/4/1965</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Balto National</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Balto</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 3 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Choy & Wilson 1001 Brantley Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

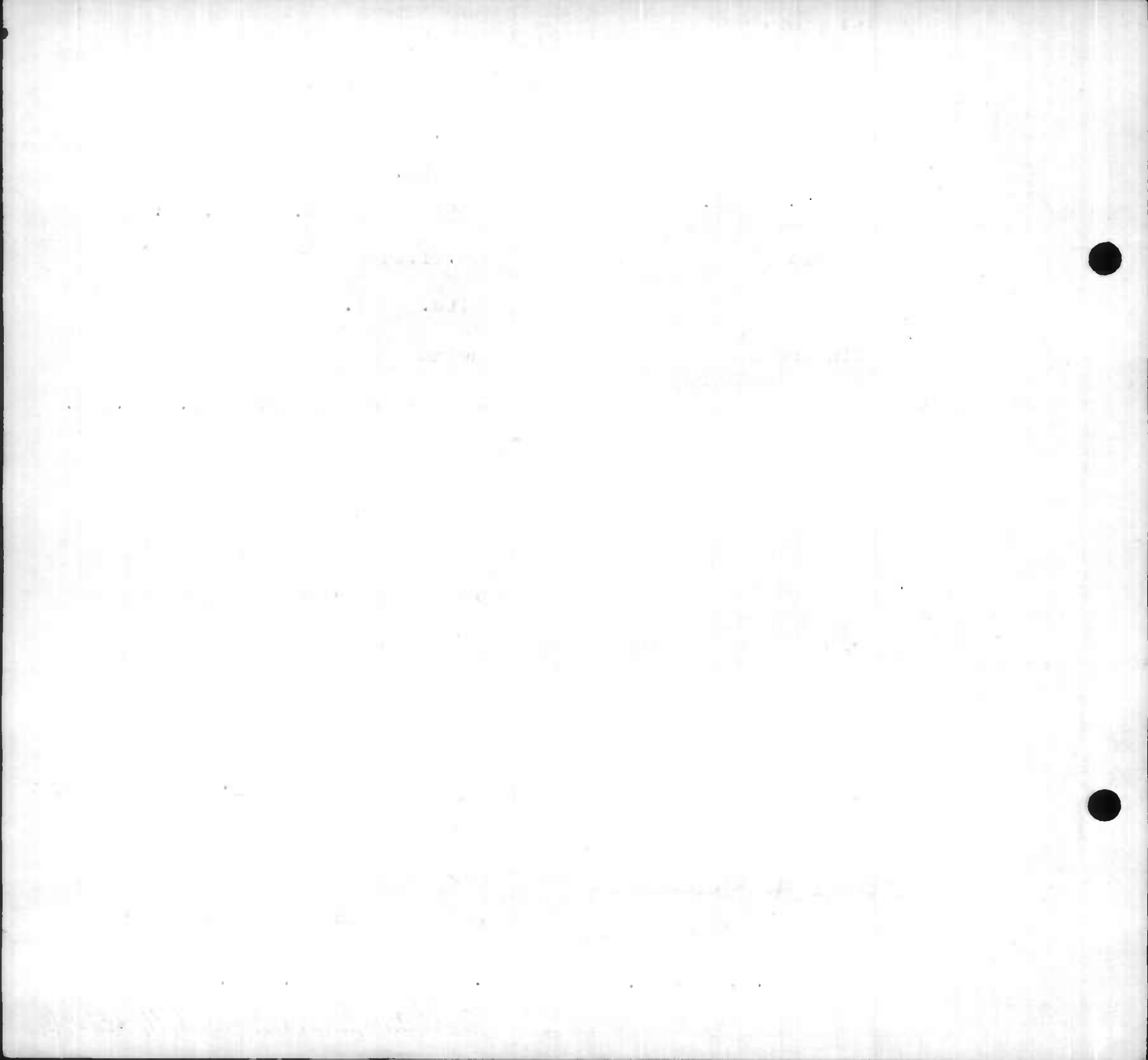
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-------------------------|--|---|--|--|--|-------------------------------|--|--|--|
| BIRTH NO. <u>3</u> 65 1245 | | | | | CERTIFICATE OF DEATH | | Registered No. <u>65</u> 1245 | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MUSOTTO, ROSALIA</u> | | | | | January 31, 1965 9:30 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u> | | | | | A. STATE <u>Md.</u> B. COUNTY <u>2804</u> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>5021 Briarclift Road</u> | | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>2/27/93</u> | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Joseph Brocato</u> | | | 14. MOTHER'S MAIDEN NAME <u>Theresa Fertitta</u> | | | ADDRESS <u>Rd</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Vincent Brocato</u> | | | | ADDRESS <u>5012 Briarclift</u> | |
| 18. <u>293X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Severe anemia, etiology unknown.</u> | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 30</u> 19 <u>65</u> to <u>Jan. 31</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan. 31</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Wm B. VandeGrift</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>February 1, 1965</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>William B. VandeGrift.</u> | | | | | 23D. ADDRESS M.D. <u>1400 N. Caroline St., Baltimore, Md. 21213</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>Feb. 3/65</u> | | | 24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 3 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR <u>W. H. L. 4101 Edmondson</u> | | | ADDRESS <u>4101 Edmondson</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

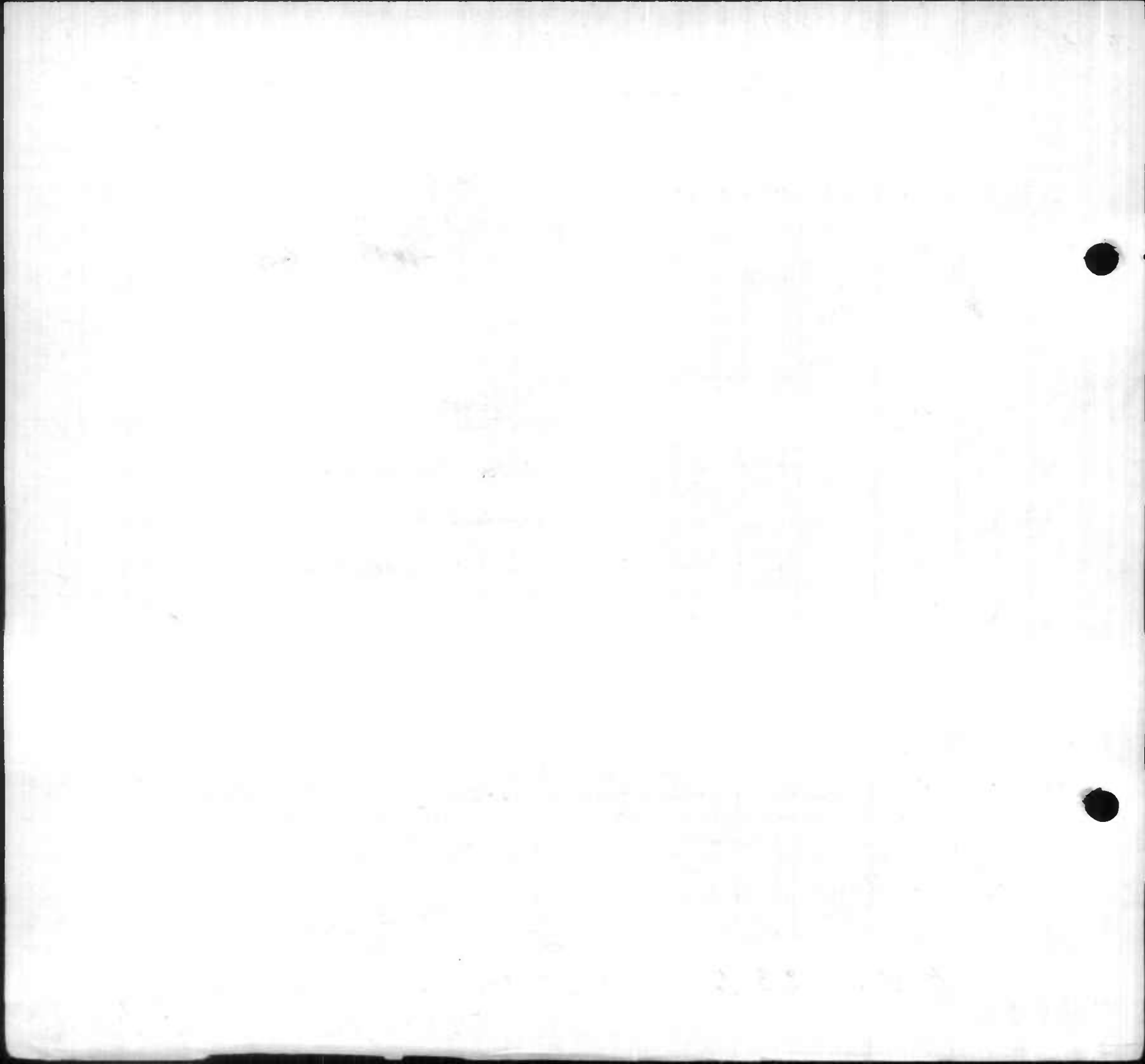
| | | | |
|---|------------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. <u>3698</u> | |
| BIRTH NO. <u>65 1246</u> | | DATE AND HOUR OF DEATH <u>65 1246</u> | |
| M.E. CASE NO. | | M. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| WILLIAM HENRY GREEN | | FEB. 1, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | |
| (If not in hospital or institution, give street address or location) | | Md. | |
| 851 George St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | Balto. | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 851 George St. Apt. 3E. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | Colored | Married | Dec. 21, 1894 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) |
| Laborer | | | 70 |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Balto. Md. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Benjamin Green | | Lucinda | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | | |
| 17. INFORMANT | | ADDRESS | |
| Lula Green 851 George St. Apt. 3E. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| ANTECEDENT CAUSES | | Cerebral hemorrhage | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | |
| | | Arterio Sclerosis Hypertension | |
| | | (C) DUE TO | |
| | | | |
| 19. DATE OF OPERATION | | 20. AUTOPSY? (Yes or No) | |
| 1965 10 21 | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-29-1965 to 2-1-1965, and that (I) (we) lost sight of the deceased on 1-31-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Frank A. Saunders | | 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Frank A. Saunders | | 1029 N. Stricker St. Baltimore Md. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | Feb. 4, 1965 | Mt. Auburn Cem. | Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS |
| FEB 3 1965 | Robert E. Farley M.D. | Williams Funeral Home | 3191 Schroeder St. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|--------------------------------------|--|---|
| BIRTH NO. 65 1247 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1247 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Gussie Adams</i> | | 2. DATE AND HOUR OF DEATH <i>1-30-65</i> <i>1:15 pm</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>18-02</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>329 N. Carrollton Ave.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>wid</i> | 8. DATE OF BIRTH <i>3-24-1899</i> | 9. AGE (In years last birthday) <i>65</i> | 10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Robert Law</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Brown</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Hattie Lee (daughter)</i> | |
| | | | | ADDRESS <i>Same</i> | |
| 18. <i>420.1 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Acute Myocardial Infarction</i> | | <i>5 days</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Arteriosclerotic Cardiovascular Disease</i> | | <i>Several years</i> | |
| | | (C) <i>Hypertensive Cardiovascular Disease</i> | | <i>Several years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <i>1-26</i> <i>1965</i> to <i>1-30</i> <i>1965</i> , that we (we) last saw the deceased alive on <i>1-30</i> <i>1965</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE <i>D. Bernard Pleet</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>1-30-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>A. Bernard Pleet</i> | | 23D. ADDRESS M.D. <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/3/1965</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Balto. National Cem.</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 3 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i> | |
| | | | | ADDRESS <i>319 N. Howard St.</i> | |



M. 320

65 1248

BALTIMORE CITY HEALTH DEPARTMENT

65 1248

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARION MATTHEWS

2. DATE AND HOUR PRONOUNCED DEAD

January 30, 1965

11:25 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

538 N. Pulaski Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 19, 1904

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Prince Edward Co., Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Matthews

14. MOTHER'S MAIDEN NAME

Elizabeth Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-05-0157

17. INFORMANT

Bertie Matthews 538 N. Pulaski St

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Feb 5/1965

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto. Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 3 1965

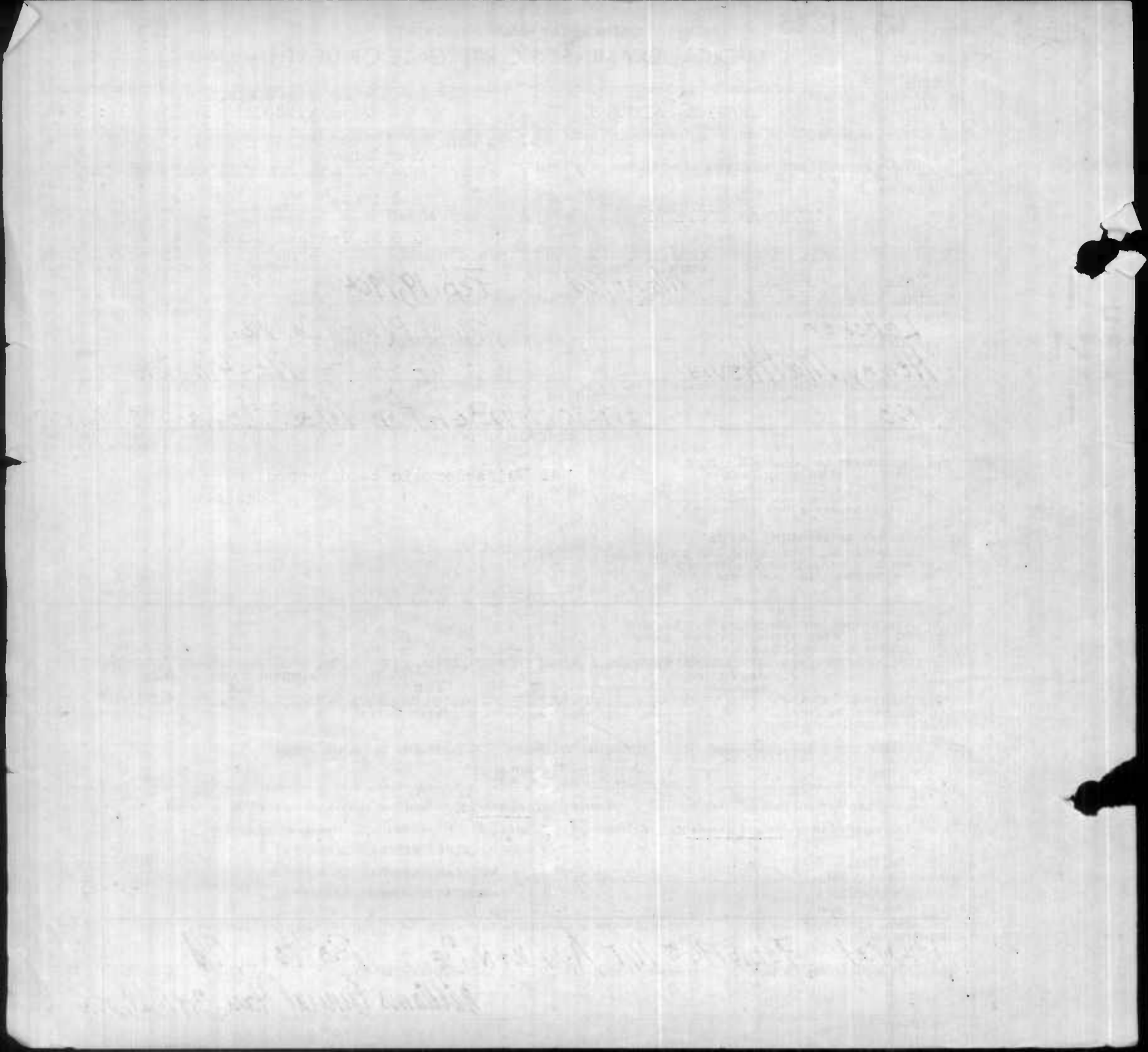
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Howard St

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

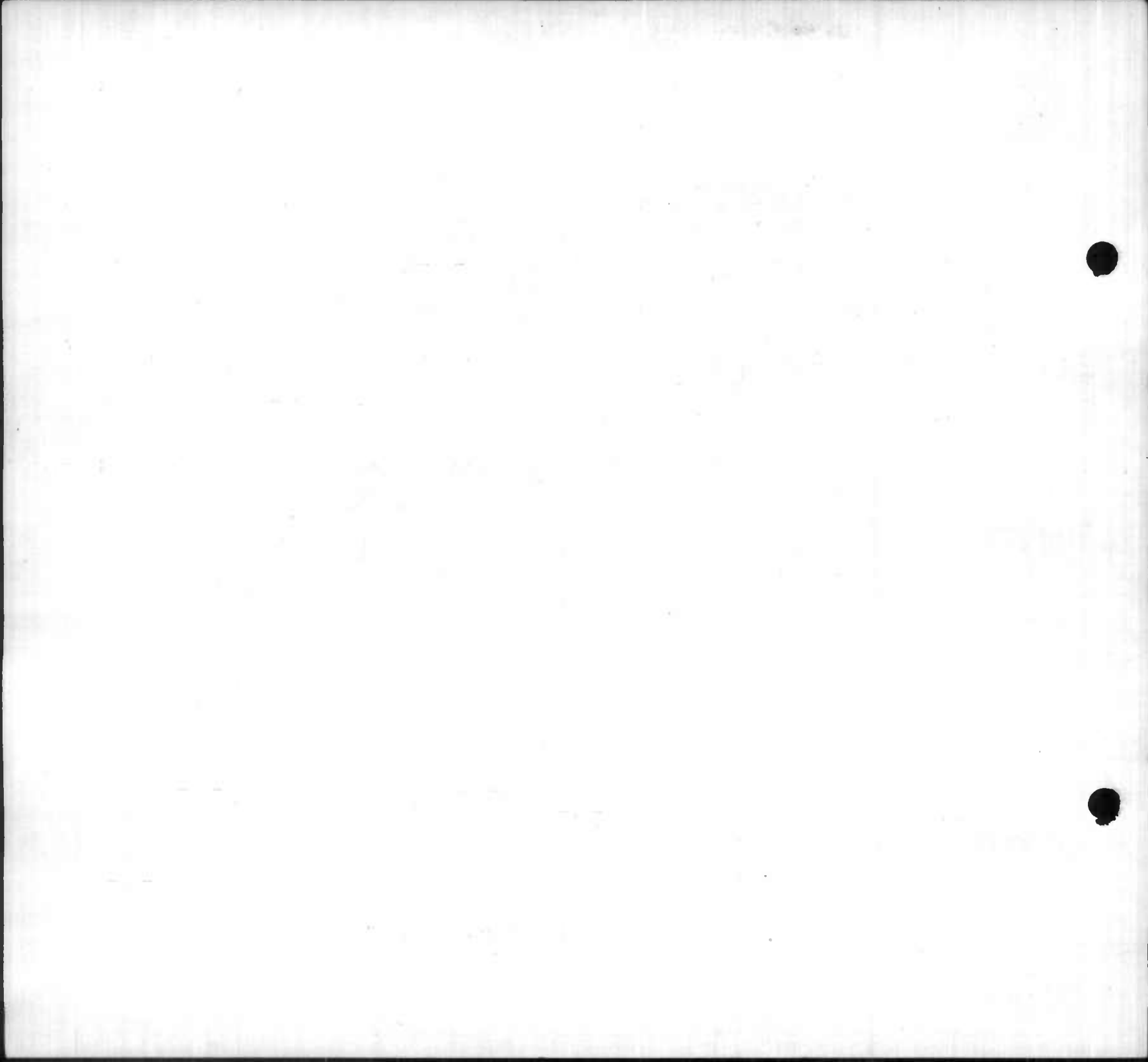
| | | | | | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 65 1249 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1249 | |
| 1. NAME OF DECEASED (Type or Print) ANNA UNK Drinks | | | 2. DATE AND HOUR 2/1/65 1 NOON M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Hospital For The Women of Maryland | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2705 | | |
| D. STREET ADDRESS (If rural, give location) 6010 Glenoak Avenue | | | | | |
| 5. SEX Female | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 3-28-1880 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Henry UNK Drinks | | |
| 14. MOTHER'S MAIDEN NAME Rose unk Wise | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT PTs. chart ADDRESS | | |
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalised A.S. disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Multiple Pulmo- nary Embolism. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-22 19 65 to 2-1 19 65 , that (I) (we) lost saw the deceased alive on 1-22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Angela A. Repair M.D. | | | 23B. DATE SIGNED 2-1-65 | | |
| 23C. PHYSICIAN'S NAME (Type) ANGELITA TOPACIO | | | 23D. ADDRESS Women's Hospital, Balto. 17, Ind | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/65 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn | |
| 24D. LOCATION (City, town, or county) Balto Md | | 24E. (State) MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR McDeeney 6062 Hay Rd ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

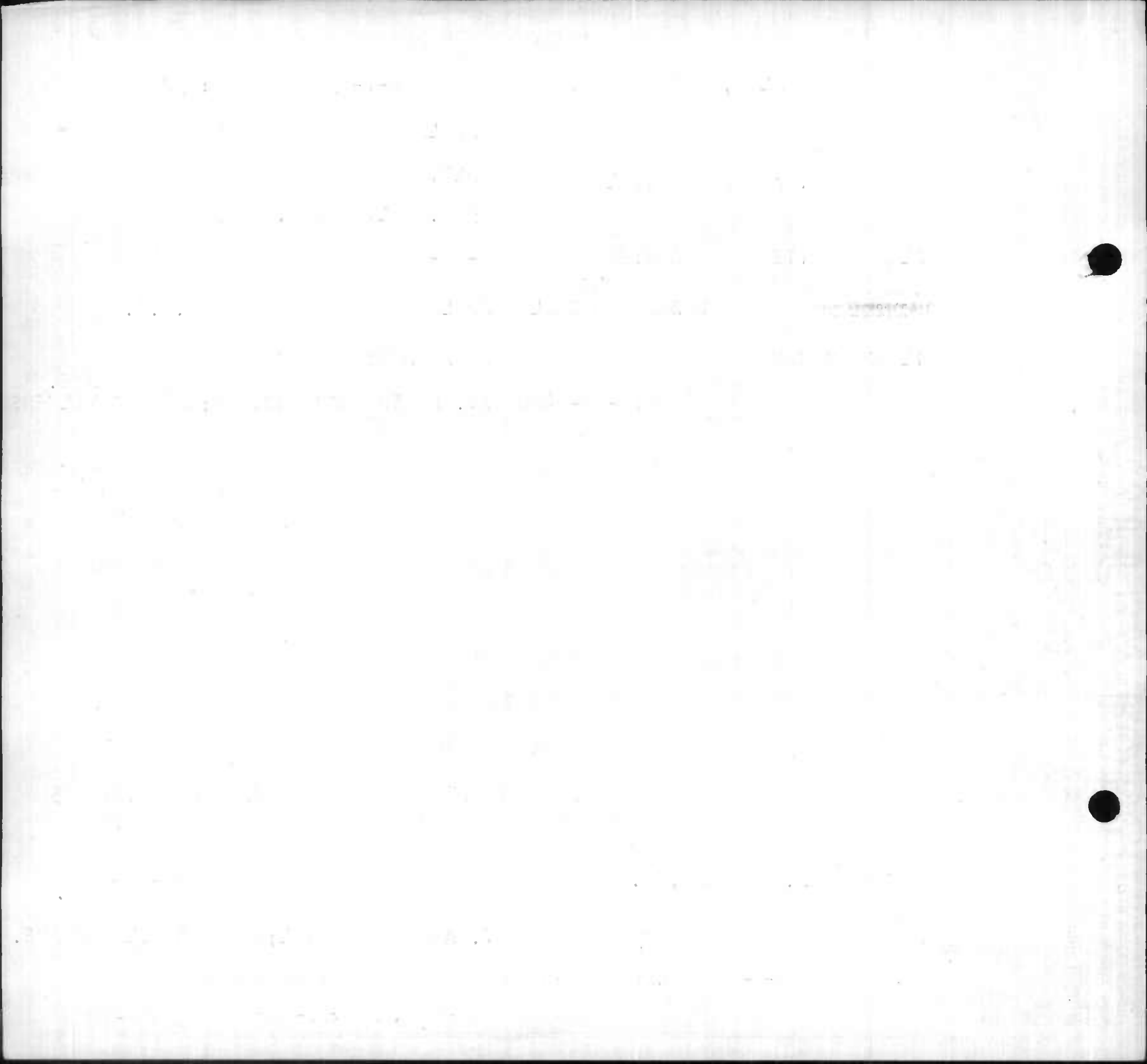
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1250 | |
|--|--|------------------|--|---|--|-----------------------------|--|--|--|---|--|
| BIRTH NO. 65-04535 65 1250 | | | | | | | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Baby boy of Carzina Nickins | | | | | | | | | | January 27, 1965 8:30 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | | | | | | | | A. STATE Maryland | |
| | | | | | | | | | | B. COUNTY | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 1200 Kevin Road | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 1-25-65 | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | |
| | | | | | | | | | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Stanton Nickins | | | | 14. MOTHER'S MAIDEN NAME Carzina Nickins | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Carzina Nickins - mother | | | |
| | | | | | | | | ADDRESS same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 776x I IMMATURITY | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1-25-64; 1-27-65 | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-25-65 19 to 1-27-65 19, that (I) (we) last saw the deceased alive on 1-27-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Lionel C. Rose M.D. | | | | | | | | | | 23B. DATE SIGNED 1-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Lionel C. Rose | | | | | | | | | | 23D. ADDRESS 1514 Division Street Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) FEB 2 1965 | | | | 24B. DATE FEB 2 1965 | | | | 24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Fink | | | |
| | | | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BOND | | | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

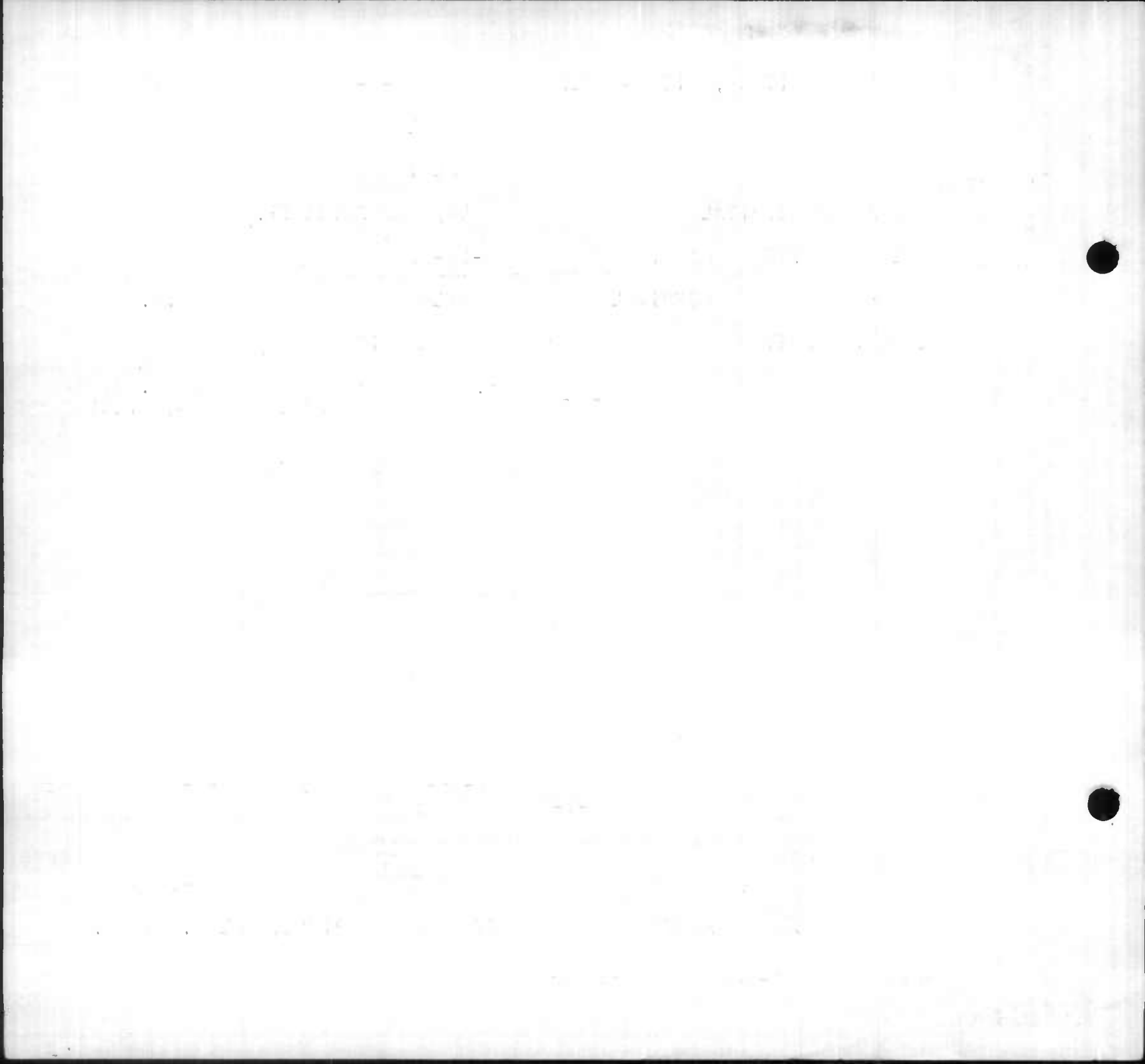
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 1251 | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 65 1251 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) FRALEY, ROY BENJAMIN | | | 2. DATE AND HOUR OF DEATH 2-1-65 10:15P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-02 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 25 N. FULTON AVE. #23 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-20-09 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME GILBERT FRALEY | | | 14. MOTHER'S MAIDEN NAME ANNA HAYES | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-07-6490 | 17. INFORMANT ADDRESS ST. AGNES HOSP RECORDS; CATON & WILKENS AVE. | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION X 2 OLD + FRESH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ALSO HEMMORHAGIC GASTRITIS & BLEEDING RESOLVER. PNEUMONITIS 2° to A) PYELONEPHRITIS | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 20 19 65 to XX FEBRUARY 1 19 65 , that (I) (we) last saw the deceased alive on FEBRUARY 1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE HENRY R. HERBERT, JR. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) <i>Henry R. Herbert Jr.</i> | | | 23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE. #29 | | |
| 24A. BURIAL CREMATION, DATE REMOVAL (Specify) Burial | | 24B. DATE 2-5-65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|---------|--|--|--|---------------------------------|--|--|--|--|------------------------|--|
| BIRTH NO. | | 65 1252 | | | | CERTIFICATE OF DEATH | | | | Registered No. 65 1252 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| | | NITSCH, RITA MADELINE | | | | 2-1-65 | | | | 12 NOON M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | A. STATE B. COUNTY | | | | | |
| ST AGNES HOSPITAL | | | | | | MARYLAND | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | | | BALTIMORE | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | | | 447 ^S BRUNSWICK ST. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| FEMALE | WHITE | MARRIED | | 9-26-21 | 43 | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| NURSE | | | | HOSPITAL | | MARYLAND | | U.S. | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| CLEMENT HEANEY | | | | | | MARY MORRIS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | | | 214-14-8457 | | Mr. George Nitsch — 447 Brunswick St. ADDRESS | | | | | |
| | | | | | | CATON AVES. 21229 | | | | | |
| | | | | | | ST AGNES HOSPITAL RECORDS, WILKINS AND | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | CAUSE OF DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) DUE TO | | | | | |
| | | | | | | Cholangiosarcoma, metastatic | | | | | |
| ANTECEDENT CAUSES | | | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (C) DUE TO | | | | | |
| | | | | | | | | | | | |
| II | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-29-65 to 2-1-65, that (I) (we) last saw the deceased alive on 2-1-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | | |
| Carmen Fratto | | | | | | | | 2-1-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | | | |
| CARMEN FRATTO | | | | | | M.D. ST AGNES HOSPITAL, BALTO. 29, MD. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | 2-4-65 | | New Cathedral Cemetery | | Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| FEB 3 1965 | | | | Robert E. Taylor, M.D. | | 1253 | | | | | |



LS: 36-25-88

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1253

BIRTH NO. 65 1253

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Eugene Paolini

2. DATE AND HOUR OF DEATH

January 30, 1965 11:10 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2909 Berwick Avenue 21214

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 1908
XXXXXX9. AGE (In years
last birthday)

X55 56

10. Under 1 Yr.
Months: Days: Hours: Min.11. Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Unemployed

11. BIRTHPLACE (State or foreign country)

Massachusetts Italy

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Carmen Paolini

14. MOTHER'S MAIDEN NAME

Seloma DelBene

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Katherine Paolini-2424 Shannon St.
Brighton, Mass.
RECORDS: BCH: 4940 Eastern Avenue #21224

18.

179.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Pulmonary Embolus
DUE TO(B) Cirrhosis of Liver
DUE TO

(C) Carcinoma of Penis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Upper Gastrointestinal Tract Bleeding
2 to Duodenal

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 30, 19 64 to January 30, 19 65
that (I) (we) last saw the deceased alive on January 30, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James R. Leonard

M.D. Attending
Phys. ☐Med.
Director ☐Stoff
Phys. ☒

23B. DATE SIGNED

January 30, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. James R. Leonard

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/3/65

24C. NAME OF CEMETERY or CREMATORY

St Michaels Cemetery

24D. LOCATION

(City, town, or county)

Boston, Mass.

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 3 1965

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

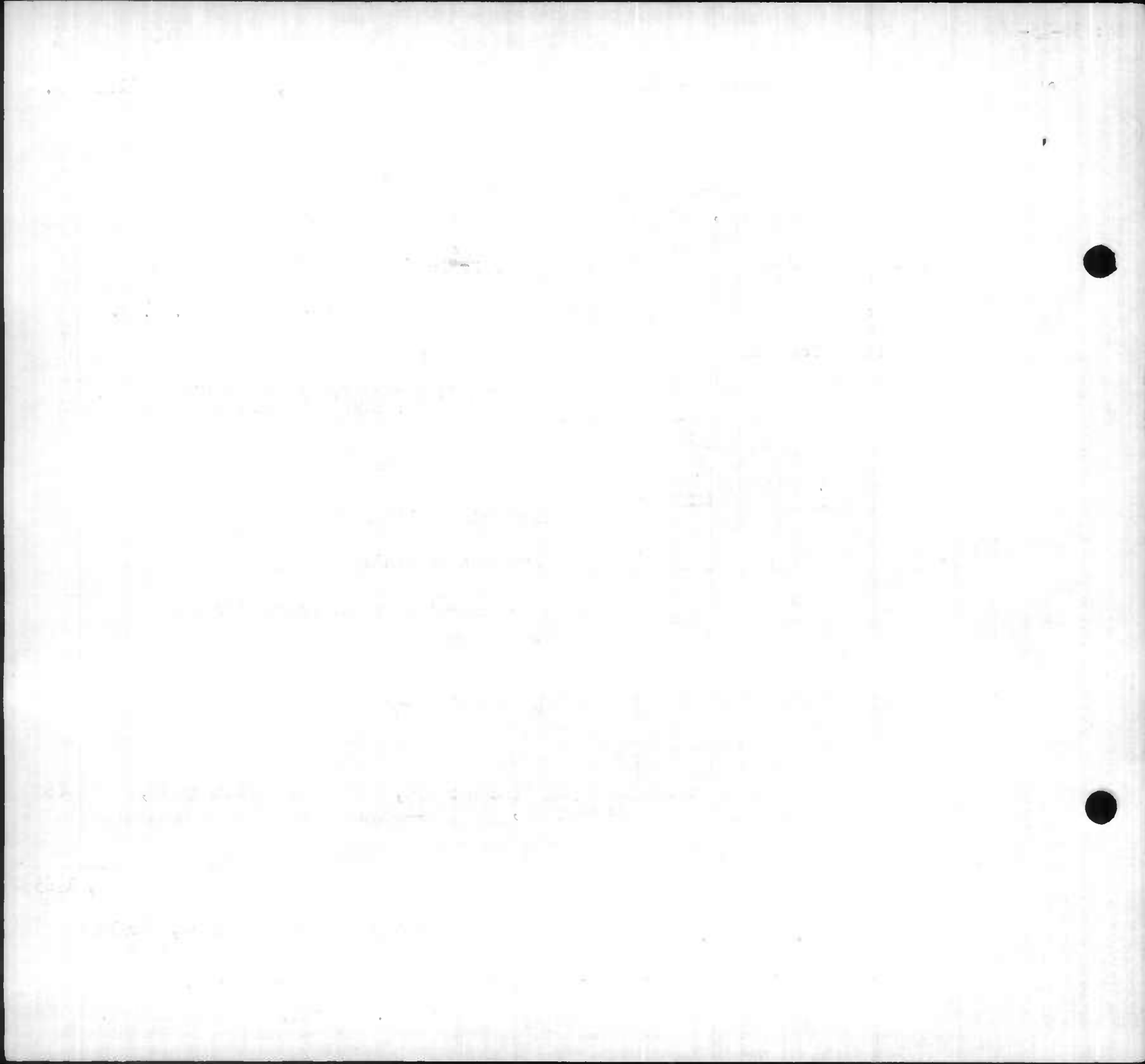
25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

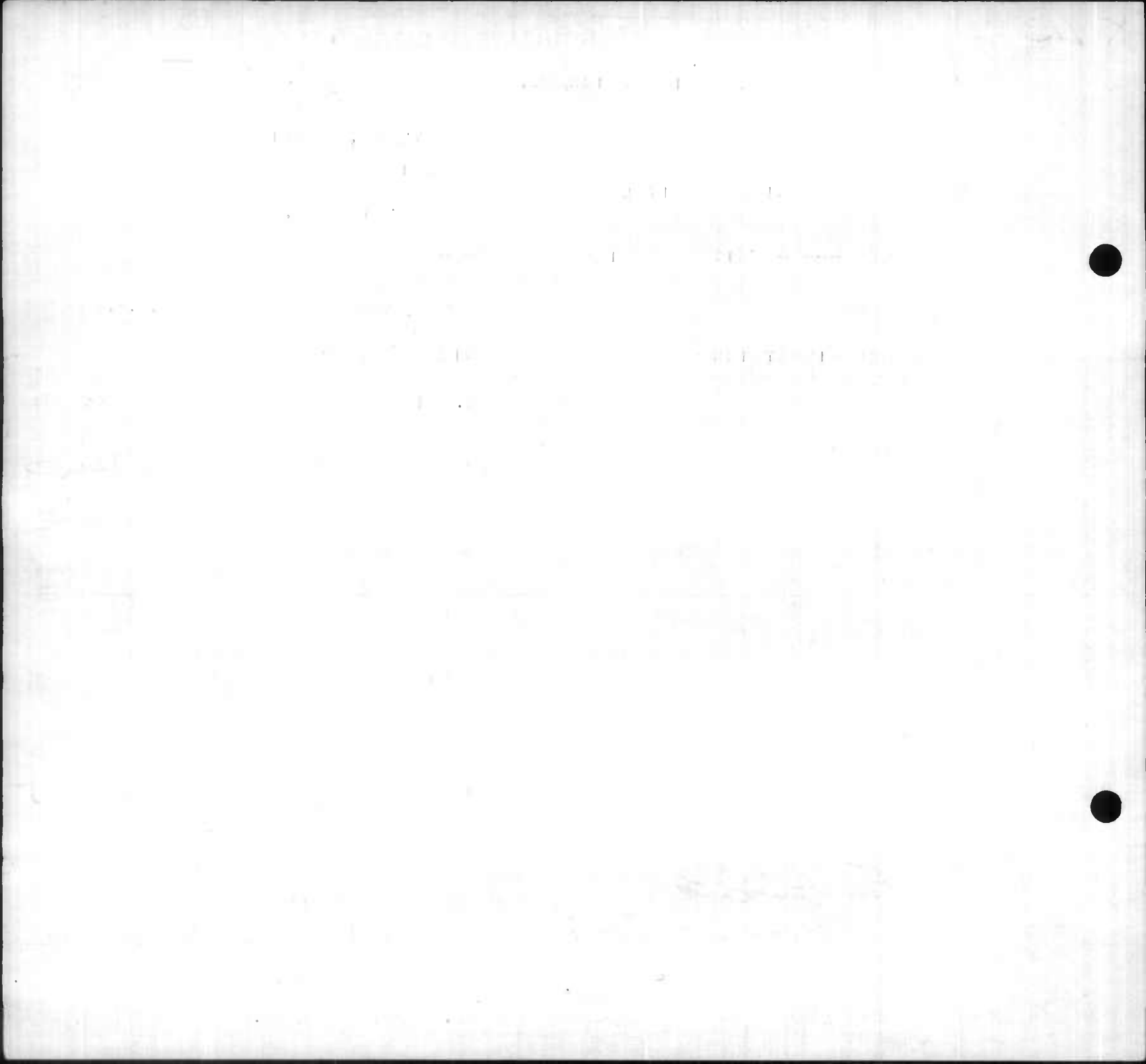
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

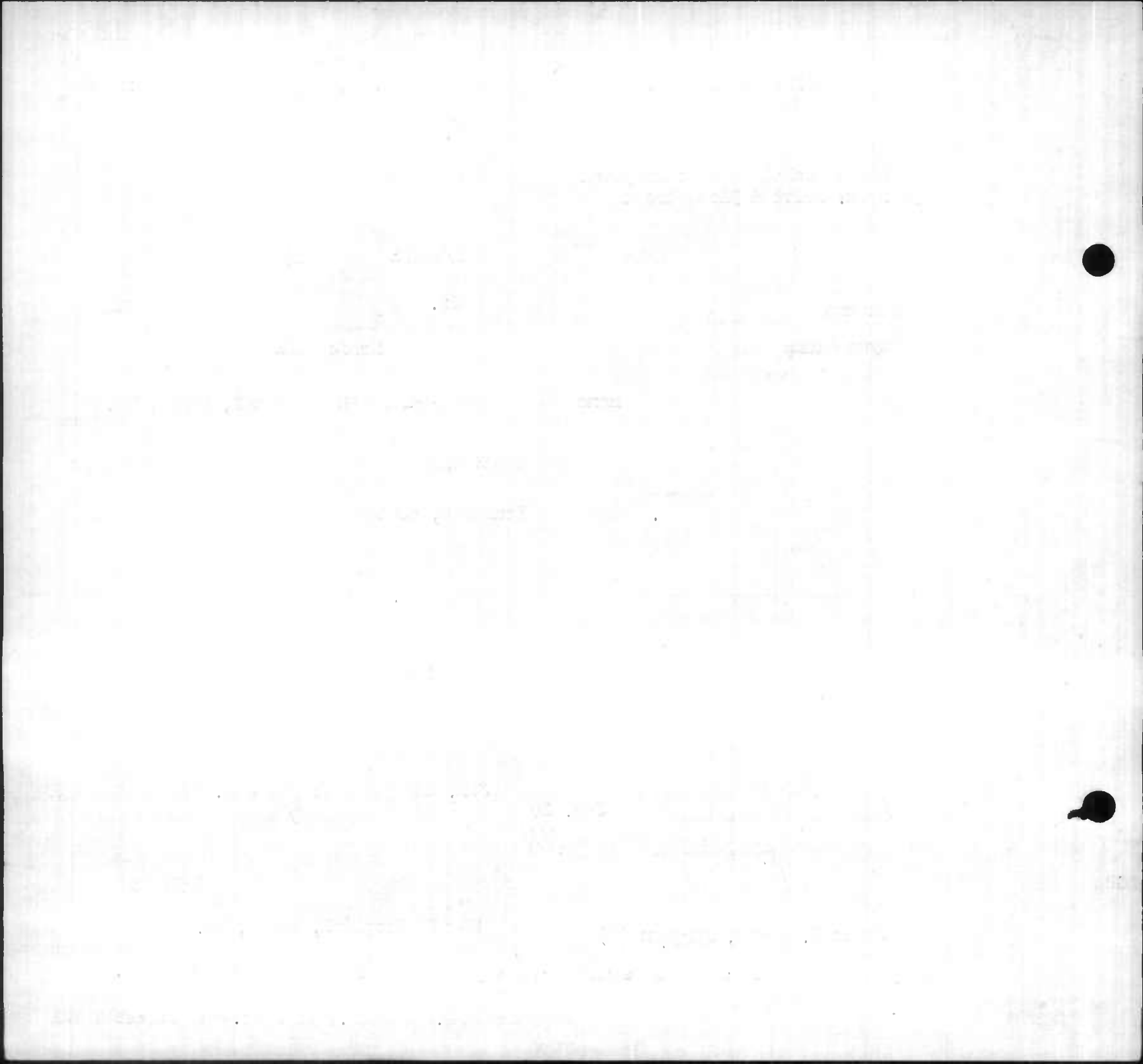
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1254 | |
|---|-----------------------|---|----------------------------|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 65 1254 | |
| BIRTH NO. 65 1254 | | M.E. CASE NO. C. | | 2. DATE AND HOUR OF DEATH 1-30/65 2:00 P.M. | |
| 1. NAME OF DECEASED (Type or Print) CHARLES KILPATRICK, Sr. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND, BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 7319 BETZ AVE. | | | |
| 5. SEX MALE | 6. RACE MALE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-7-08 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES KILPATRICK | | 14. MOTHER'S MAIDEN NAME ANNIE BRADSHAW | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-07-5448 | | 17. INFORMANT ADDRESS Mrs. Wilhelmina Kilpatrick, 7319 Betz Ave, Balto | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 692.1 Staph Septicemia Staph abscess bullock | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 days 1 1/2 wks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-14 19 65 to 1-30 19 65, that (I) (we) last saw the deceased alive on 1-30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  23C. PHYSICIAN'S NAME (Typo) BRUCE LEE EVANS | | | | 23B. DATE SIGNED M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23D. ADDRESS M.D. Johns Hopkins Hopkins | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens | |
| 24D. LOCATION Bel Air, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Hamilton, Inc., 6009 Harford Rd, 22214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

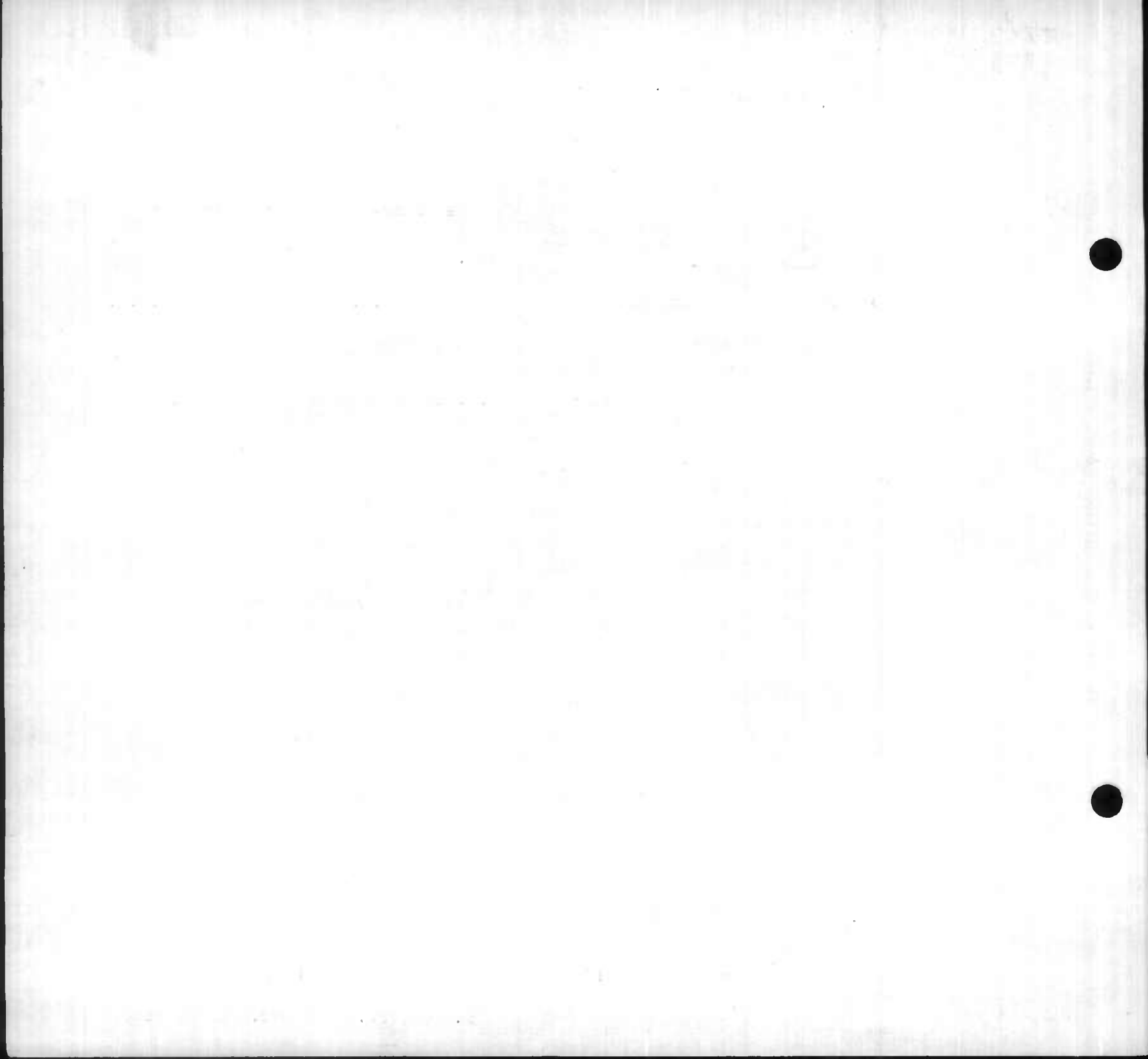
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|---|--|---|--|--|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1255 | | | | |
| BIRTH NO. 65 1255 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) ARLINE SUSAN STUMP | | | | | 2. DATE AND HOUR OF DEATH Jan. 29, 1965 9:50 AM M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dauberville | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED Single | | 8. DATE OF BIRTH 8/10/51 | 9. AGE (In years last birthday) 13 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Wayne Stump | | | | 14. MOTHER'S MAIDEN NAME Mamie Noll | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | | |
| 18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septicemia (A) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH 4-5 days | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Leukemia, acute (B) DUE TO | | | | | Unknown | | | | |
| (C) DUE TO | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1965 to Jan. 29, 1965 , that (I) (we) last saw the deceased alive on Jan. 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE James H. Frank | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 1/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) James H. Frank, Surgeon (R) | | | | | 23D. ADDRESS M.D. US PHS Hospital, Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 1-29-65 | | 24C. NAME OF CEMETERY or CREMATORY Belleham's Cemetery | | 24D. LOCATION (City, town, or county) (State) Center Township, Berks Co., Pa | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, 21202 | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

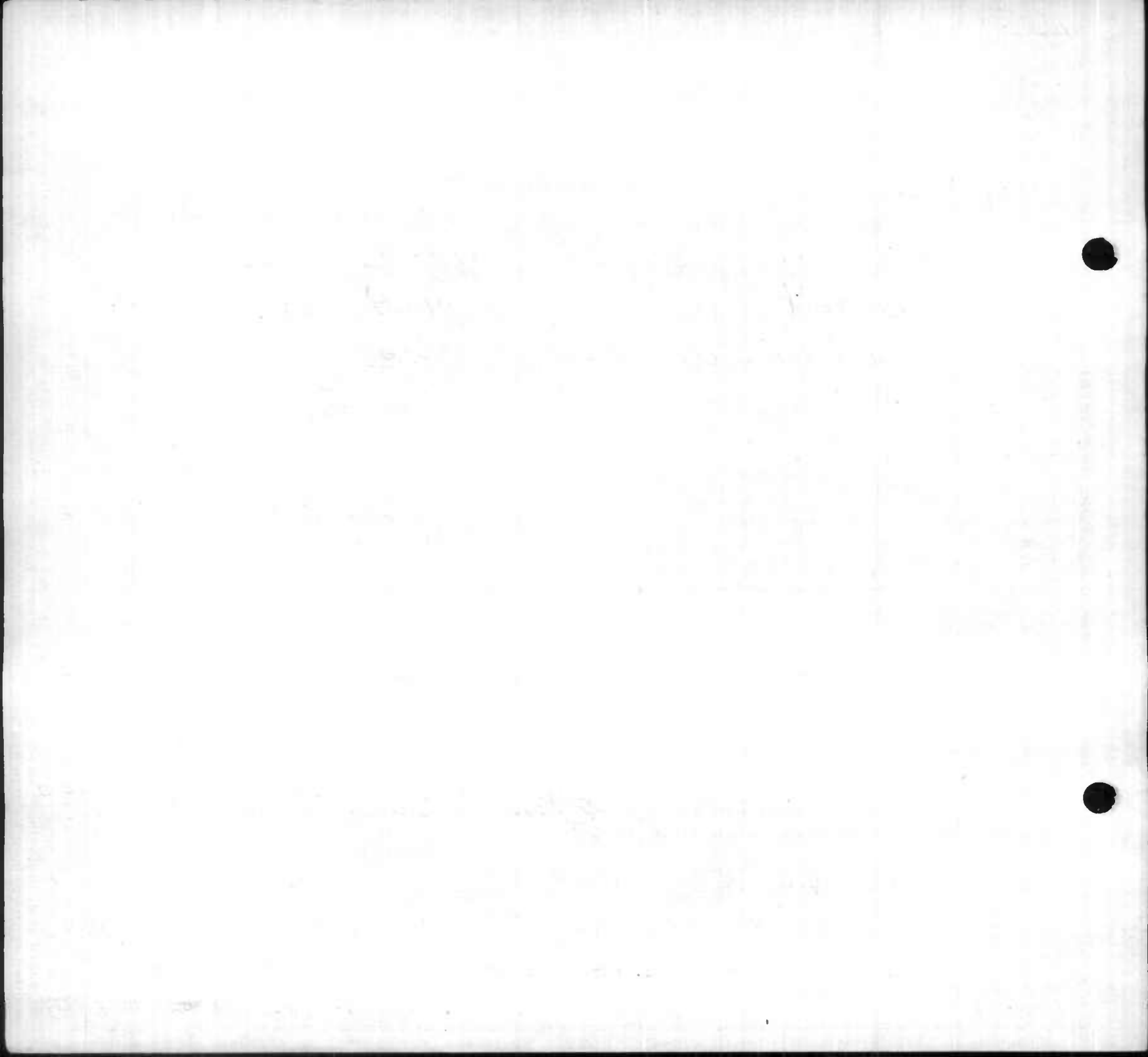
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1256 | |
|--|---------------------|--|--|--|--|
| BIRTH NO. 65 1256 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Russell, Claude F.</i> | | 2. DATE AND HOUR OF DEATH <i>1/29/65 10:25pm</i> P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-17</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI Hosp Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>Belvedere and Green Spring Ave</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>Aug. 23, 1903</i> | 9. AGE (In years last birthday) <i>61</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dispatcher</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Transit Co</i> | | 11. BIRTHPLACE (State or foreign country) <i>Kearney, N. J.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | 13. FATHER'S NAME <i>Albert Russell</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Catherine W. od</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. <i>521-07-4895</i> | | | 17. INFORMANT ADDRESS <i>J. H. Geigle Funeral Home, Harrisburg, Pa</i> | | |
| 18. <i>420.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Pulmonary edema</i> DUE TO (B) <i>Arteriosclerotic heart disease</i> DUE TO (C) <i>Atrial flutter - fibrillation</i> <i>Pulmonary embolus.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 yrs.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8:50pm 1/29/65</i> to <i>10:25pm 1/29/65</i> , that (I) (we) last saw the deceased alive on <i>1024 1/29/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Skeldon C. Krawitz</i> | | | | 23B. DATE SIGNED <i>1/29/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | | 24B. DATE <i>1-30-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Dauphin Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Dauphin, Pa</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 3 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook, Inc., 1217 St. Paul Street, 21202</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

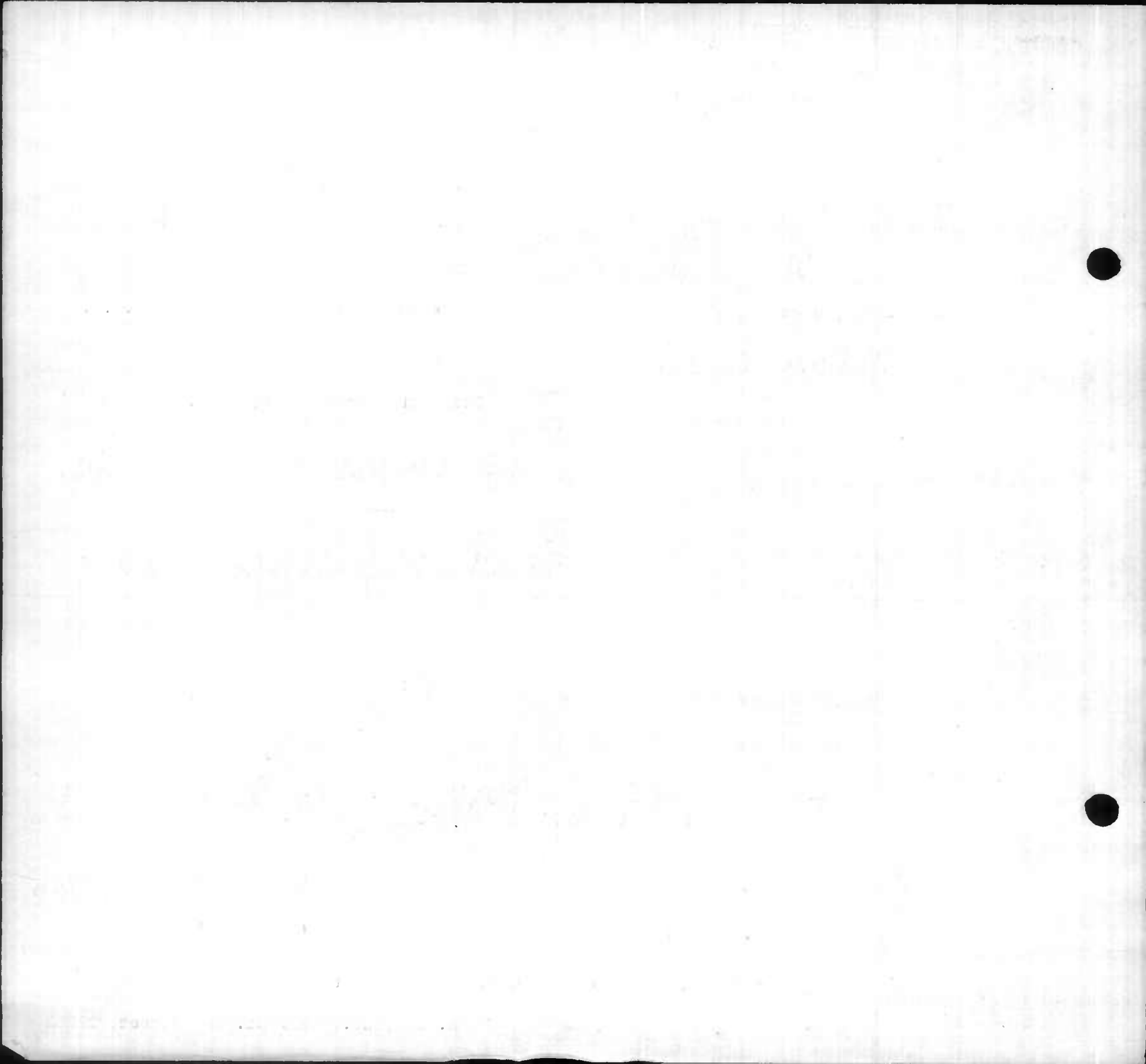
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1257 | |
|--|--|--|--|---|--|
| BIRTH NO. 65 1257 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Kenneth Francis X. O'Brien</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>29 Jan 65</i> | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hosp</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| 5. SEX <i>Male</i> | | 6. RACE <i>Cauc</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | |
| 8. DATE OF BIRTH <i>5/9/53</i> | | 9. AGE (In years last birthday) <i>12</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 13. FATHER'S NAME <i>William D. O'Brien</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Joe Laeth</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>NA</i> | |
| 17. INFORMANT <i>Parents</i> | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) <i>Leukemic Transformation</i> | | <i>9 mo -</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Lymphosarcoma</i> | | <i>9 mo -</i> | |
| II | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2 None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 1964</i> to <i>Jan 29 1965</i> , that (I) (we) last saw the deceased alive on <i>29 Jan 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>D.E. Krickerboker</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>29 Jan 64</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Donald E. Krickerboker</i> | | 23D. ADDRESS <i>University of Maryland Hosp.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | | 24B. DATE <i>2-2-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St. Peter's Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Saratoga Springs, New York</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 3 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Towson, Inc., 1050 York Road, TOWSON</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1258 | |
|---|--------------|--|----------------------------|--|---|
| BIRTH NO. 65 1258 | | CERTIFICATE OF DEATH | | REGISTERED NO. 65 1258 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Anna Griffith | | 2. DATE AND HOUR OF DEATH February 1, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #14 27-38 | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 5815 Millington Avenue | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 6-4-98 | 9. AGE (In years last birthday) 66 | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME William Tennant | | 14. MOTHER'S MAIDEN NAME Alice Stickler | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Griffith Funeral Home, 655 E. Broad St Pamaqua, Pa | |
| 18. 2043 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Perforated Viscus | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Drute Blastic Leukemia | | (B) DUE TO | | One year | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from May 27 1964 to February 1 1965, that (I) (we) last saw the deceased alive on February 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. J. Harwick | | | | 23B. DATE SIGNED Feb 1, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) HERBERT J. HARWICK | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 2-1-65 | | 24C. NAME OF CEMETERY or CREMATORY Odd Fellow Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Schuylkill County, Pa | | 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

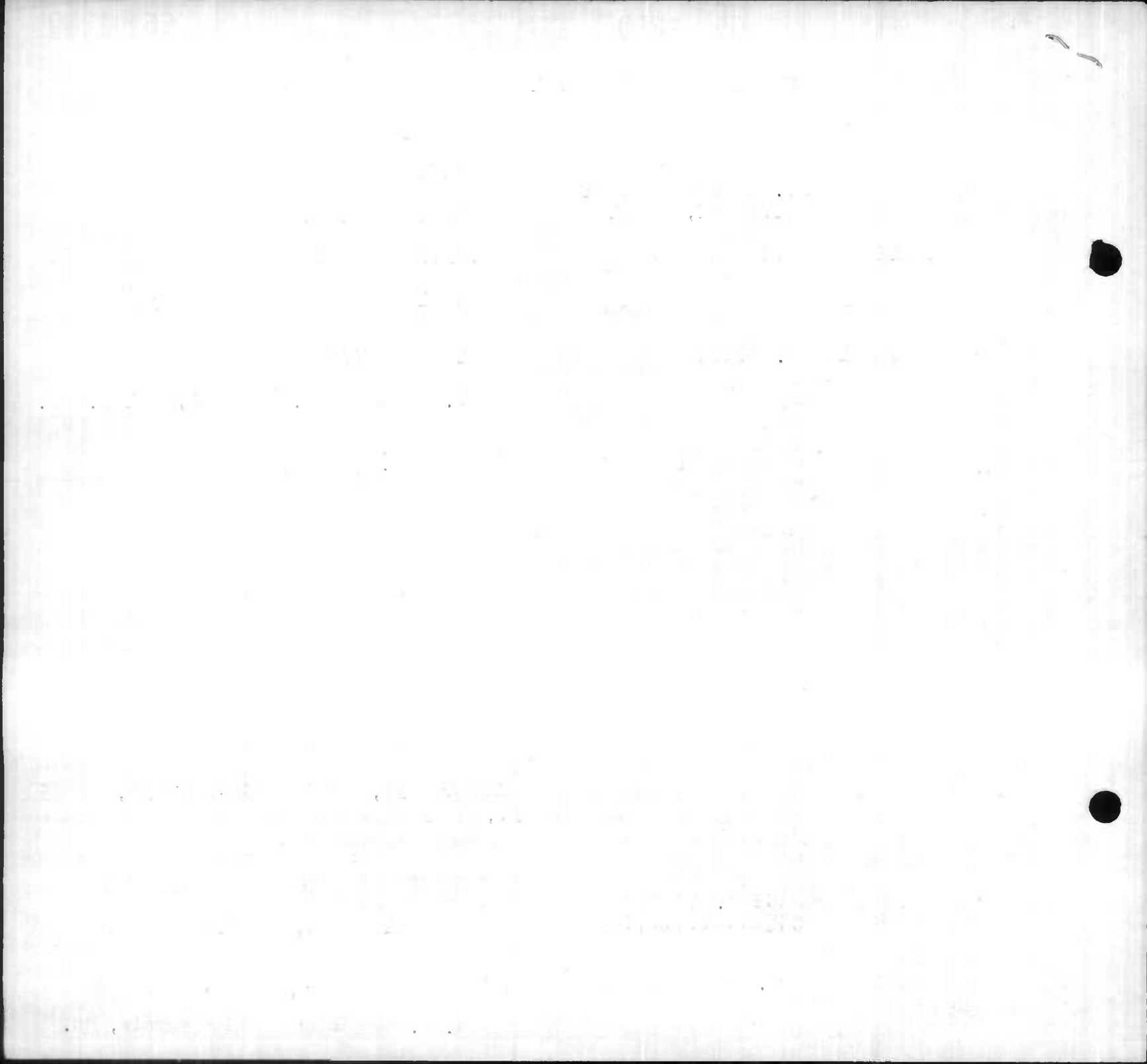
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1259 | |
|---|--|---|--|--|--|--|--|
| BIRTH NO. 65 1259 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles Maurice J Hedbee</i> | | 2. DATE AND HOUR OF DEATH <i>Feb-2-65- 7 am</i> M. | |
| 3. PLACE OF DEATH <i>at his residence - Ambassador apt-718</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | | |
| 5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | | | | 8. DATE OF BIRTH <i>Feb 5/1882</i> | | 9. AGE (in years last birthday) <i>82</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Oil Industry</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | | | 13. FATHER'S NAME <i>Jas. S. Hedbee</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Elizabeth Manley</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW-1- 265-07-2768 T.C. Hedbee (yephus) 1-14/10-1-31/10</i> | | | |
| 16. SOCIAL SECURITY NO. <i>265-07-2768</i> | | | | 17. INFORMANT <i>T.C. Hedbee (yephus)</i> ADDRESS <i>14701 L. Bk. Balto.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>451X I Ruptured Abdominal Aortic Aneurysm</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerosis ? yrs</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pernicious anemia 35 yrs</i> <i>Chronic Obstructive Pulmonary Disease 5 yrs</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6/1/6</i> 19 <i>43</i> to <i>Feb. 2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>1/8/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Francis W. Gluck</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <i>2/2/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Francis W. Gluck</i> | | | | 23D. ADDRESS <i>100 W University Pkwy</i> M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <i>Burial Feb</i> | | | | <i>Cathedral</i> | | <i>Balto-29-Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 3 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farber M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Stewart M. Munn</i> | | ADDRESS <i>1020 W. North Ave</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|---|---|--|---|------------------------------------|--|
| 65 1260 CERTIFICATE OF DEATH | | | | | Registered No. 65 1260 | | | | |
| 1. NAME OF DECEASED (Type or Print) STADER BABY GIRL | | | | | 2. DATE AND HOUR OF DEATH 1/31/65 9 AM | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERN D. STREET ADDRESS (If rural, give location) RT 1 BOX 548 | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 1/31/65 | 9. AGE (In years last birthday) NEWBORN | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME CHARLES J. STADER | | | | | 14. MOTHER'S MAIDEN NAME GLADYS BUTTRUM | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS ST. AGNES HOSP. RECORDS, BALTO. MD. | | | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Imaturity (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 31, 1965 to JANUARY 31, 1965 , that (I) (we) last saw the deceased alive on JANUARY 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Grace P. Ayuyao GRACE P. AYUYAO | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) XXXXXXXXXXXXXXXXXX | | | | | 23D. ADDRESS BALTIMORE, MARYLAND | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Feb. 2/65 | | 24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park | | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS R. V. Singleton Glen Burnie, Md. | | | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 1261 | |
|--|------------------|--|---------------------------------|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| M.E. CASE NO. | | X | | | |
| 1. NAME OF DECEASED (Type or Print) | | E NORMAN E RIPPEON | | 2. DATE AND HOUR PRONOUNCED DEAD 1-31-65 7:55 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Carroll C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt. Airy D. STREET ADDRESS (If rural, give location) Main Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Nov. 5 1911 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | 10B. KIND OF BUSINESS OR INDUSTRY Feed | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Harry N. Rinneon | | 14. MOTHER'S MAIDEN NAME Maude Etchison | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-16-1735 | | 17. INFORMANT Mrs Carrie Rippeon Mt. Airy, Md. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) Pulmonary fat embolism - Complicating fracture of arm and base of skull ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Sepsis OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Factory | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rear of Continental Can Co., 3000 Dundalk Avenue | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 27 1965 App. 11:15 AM | | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell from roof when roof collapsed - Fell off ladder | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE PETER W. RIECKERT, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2/4/65 | | 23C. NAME OF CEMETERY or CREMATORY Pine Grove Cemetery | |
| 23D. LOCATION (City, town, or county) (State) Mt. Airy, Md. | | | | | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR C.M. Waltz Box 241 Sykesville, Md. | |

WALTON'S PROPOSAL

12/1/1911

1
H 410

65 1262

BALTIMORE CITY HEALTH DEPARTMENT

65 1262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|---|-------------------------|---|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Otilie TILLIE HOLUB | | | 2. DATE AND HOUR PRONOUNCED DEAD 1-31-65 8:50 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. JOSEPH'S HOSPITAL - DOA | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 16 Fullerton Heights Avenue 21236 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10-29-1893 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Chesovolkia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Unknown Trunka | | |
| 14. MOTHER'S MAIDEN NAME Tina Unknown | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT ADDRESS Mr Adolf Holub 16 Fullerton Heights Aven | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2-3-1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. DATE SIGNED 2-1-65 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2-3-1965 | | 23C. NAME of CEMETERY or CREMATORY Bohemian National Cem. | |
| 23D. LOCATION (City, town, or county) (State) Baltimore Md | | 24A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | | |
| 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road | | | |

WILLIAM B. DODGE

WAS COUNTRY

WILLIAM B. DODGE

WILLIAM B. DODGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|------------------------------------|--|--|
| BIRTH NO. 65 1263 | | CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1263 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SCHAUB, ESTELLE ESTELLE | | 2. DATE AND HOUR OF DEATH 1-31-65 6:25AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | D. STREET ADDRESS (If rural, give location) 4423 OLD FREEDRICK ROAD | | FREDERICK ROAD | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 6-13-89 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Pulaski, Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME REUBEN THOMAS Rupe | | 14. MOTHER'S MAIDEN NAME LAVINAA KRINER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-26-5641 | | 17. INFORMANT Mrs Edward Martin ADDRESS 4423 Old Frederick Road, Baltimore Md | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION | | CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 22 DAYS UNKNOWN | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this X hospital) attended the deceased from 1.9 19 65 to 1.31 19 65 , that (I) (X) last saw the deceased alive on 1.31 19 65 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W.T. Maxson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1.31.65 | |
| 23C. PHYSICIAN'S NAME (Type) W.T. MAXSON | | 23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY Rest Haven Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Hagerstown, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Andrew K. Coffman, Hagerstown, Md | |

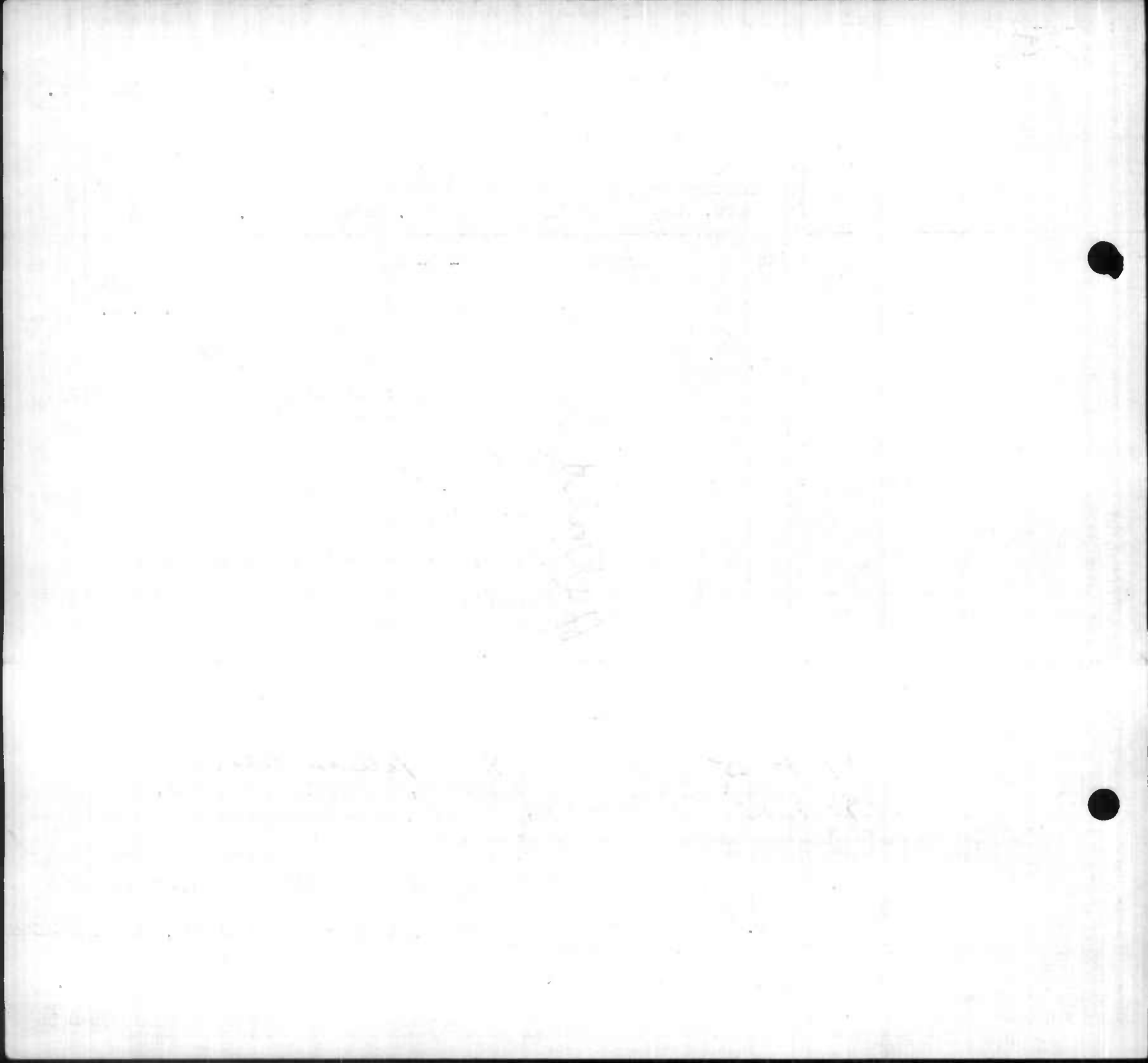
Letter form Johns Hopkins Hospital correcting errors. CpB

LS: 22-63-67
A 32

RELEASED ON APPROVAL BY MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

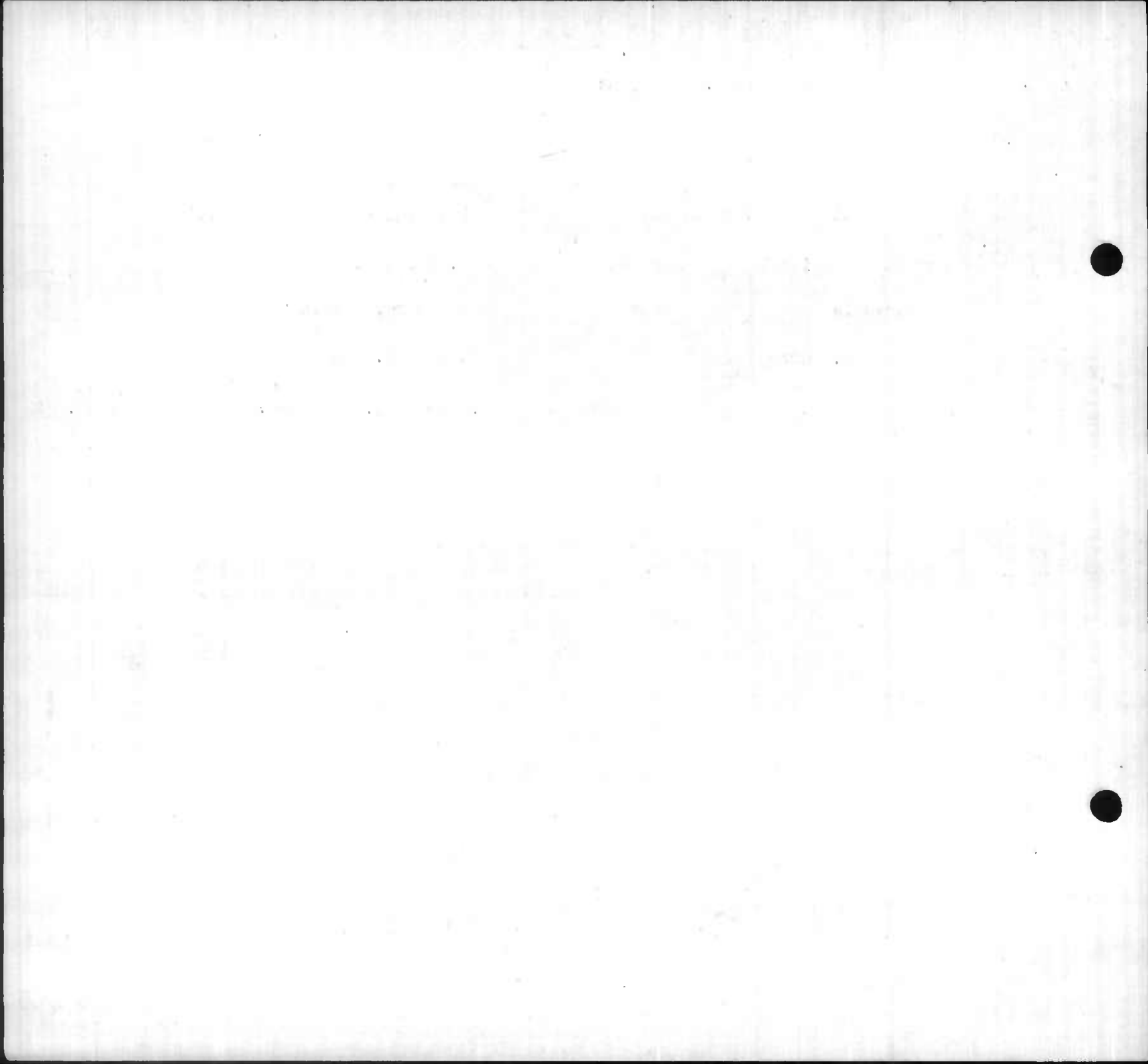
| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. 65 1264 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1264 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Roxie (Martha) Adkins | | January 31, 1965 | | 12:50 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland | | 27-05 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| Female | | White | | Married | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 9-26-88 | | 76 | | U. S. A. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Maryland | | U. S. A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| George W. Carrer | | Martha Miller | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | RECORDS: BCH: 4940 Eastern Avenue #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | 19. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| E904.01 | | Hip Fracture | | | |
| ANTECEDENT CAUSES | | Hypertension | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Arteriosclerotic Cardio Vascular Disease | | | |
| II | | Pneumonia | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Acute Gastric Dilation | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| <input checked="" type="checkbox"/> | | Home | | Home | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 1 17 65 | | | | fell in bathroom | |
| 22. I certify that (I) (this hospital) attended the deceased from January 18, 19 65 to January 31, 19 65, that (I) (we) last saw the deceased alive on January 31, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Richard Lane | | | | January 31, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Richard Lane | | | | 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-4-1965 | | Belair Memorial Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| N8200 FEB 3 1965 | | Robert E. Tarkenton | | Lassahn Funeral Home 7401 Belair Road 36 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1265 | |
|--|---|---|---|---|-----------------------------|---|------------------------------|
| BIRTH NO. 65 1265 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Beatrice K. Milbourne | | | | 2. DATE AND HOUR OF DEATH February 1, 1965 6:30 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Hood Nursing Home 5313 Edmondson Avenue | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY Baltimore | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 251 Gralan Road 21228 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Sept. 25, 1891 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Thomas J. Burns | | | | 14. MOTHER'S MAIDEN NAME Nellie L. Flannery | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. Elwood O. Milbourne | | ADDRESS 251 Gralan Road Catonsville, Md. 28 | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Pulmonary edema (A) DUE TO | | few days. | |
| | | | | Congestive heart failure (B) DUE TO | | | |
| | | | | Generalized arteriosclerosis (C) cardiac muscle disease | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Cerebral vascular accident | | | |
| | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1960 to February 1, 1965 , that (I) (we) last saw the deceased alive on 1/27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John M. Gerwig Jr. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 2/2/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) JOHN M. GERWIG JR M.D. | | | | 23D. ADDRESS 400 Gralan Rd. Baltimore 28 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/1965 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Fisher & Son Baltimore, Maryland 17 North & Park Avenue | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1266 | |
|--|-------------------------|---|--|---|-----------------------------|--|------------------------------|
| BIRTH NO. 65 1266 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type in Print) KIRBY GEORGE W. | | 2. DATE AND HOUR OF DEATH 11/30/65 4:30 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital Linden Avenue and Madison | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2016 Maryland Avenue 18 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Dec. 22, 1874 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY A. & P. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME ? Kirby | | | | 14. MOTHER'S MAIDEN NAME Mary Dugan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 222-01-2024 | | 17. INFORMANT Mrs. Mae L. Kirby | | ADDRESS 2016 Maryland Avenue Baltimore, Maryland 18 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary artery occlusion Minutes Arteriosclerotic Cardiovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Benign prostatic hypertrophy 2 wks. prostatic calc. acute retention | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED prostate | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 26, 1965 to Jan. 30, 1965 . that (I) (we) last saw the deceased alive on Jan. 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Carl F. Berner | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 11/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) CARL F. BERNER, | | | | 23D. ADDRESS Maryland General Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/3/1965 | | 24C. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Easton, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons | | ADDRESS Baltimore, Md. 21217 | |



LS: 39-45-42

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1267

BIRTH NO. 65 1267

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Thomas
William Ammons

2. DATE AND HOUR OF DEATH

February 2, 1965 2:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

115 W. Barre Street 21201

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

11-21-80

9. AGE (In years
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crossing Watchman Retired

B & O

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-14-0892

17. INFORMANT

Mrs. George Gray Baltimore, Md. 21205

ADDRESS

5002 East Preston Street

INTERVAL BETWEEN
ONSET AND DEATH

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia
DUE TO

12 Hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 9, 19 64 to February 2, 19 65,
that (I) (we) last saw the deceased alive on February 2, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. Robert Cooke

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

February 2, 1965

23C. PHYSICIAN'S
NAME (Type)

C. Robert Cooke

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

2/3/65

24C. NAME OF CEMETERY or CREMATORY

Woods Methodist Church Cem., Chesterfield Co., Virginia

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 3 1965

25B. NAME OF REGISTRAR

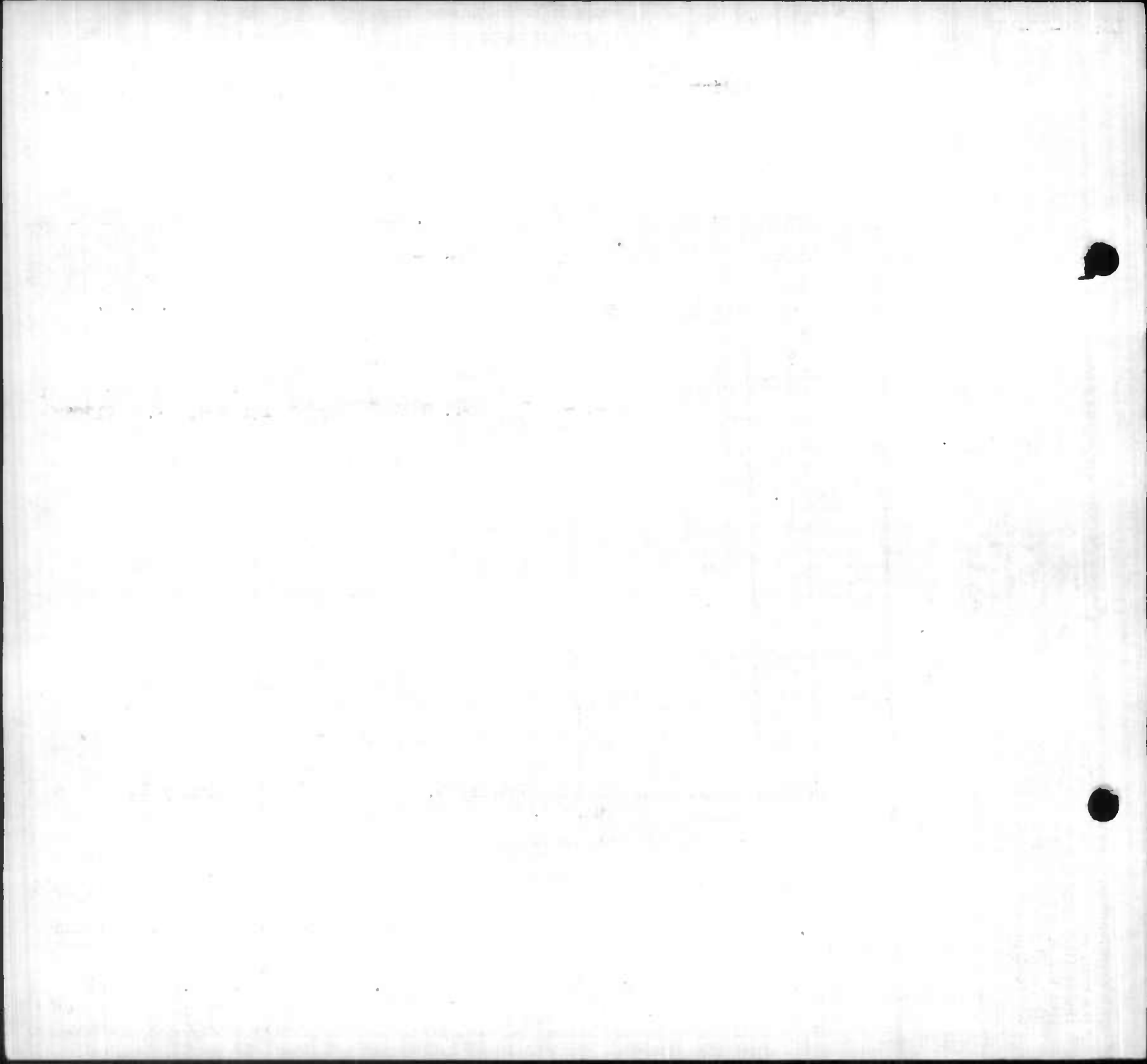
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Wm. J. Jackson & Sons with P. J. Brown

ADDRESS

Baltimore, Md. 17



1
T. 520

65 1268

BALTIMORE CITY HEALTH DEPARTMENT

65 1268

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY J. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965

11:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

755 W. Lexington Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

755 W. Lexington Street, Apt. 109

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

2/2/11

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Thomas

14. MOTHER'S MAIDEN NAME

Ida Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Thomas 755 W Lexington

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Carcinoma of lung
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-2-65

John E. Adams, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/6/65

23C. NAME of CEMETERY or CREMATORY

mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 4 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles Arice 661 W. Barre

WALTER HORTON

H. 620

65 1269

BALTIMORE CITY HEALTH DEPARTMENT

65 1269

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

2-1-65

11:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

27 S. EDEN STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 S. Eden Street 21231

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Unknown

8. DATE OF BIRTH

Unknown

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Not Known

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Purulent bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

2-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-3-65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn Ind ✓

24A. DATE REC'D BY HEALTH DEPT.

FEB 4 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St

ADDRESS

Charles A. Rose & Son
2-3-00, 1st. Class
Baltimore Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------------|---|--|---|---|
| BIRTH NO. 65 1270 | | CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1270 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Walter Davis (WALTER A. DAVIS) | | 2. DATE AND HOUR OF DEATH February 2, 1965 1:15 a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-08 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore | | D. STREET ADDRESS (If rural, give location) 708 Grantley St. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 22, 1917 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME David Davis | | 14. MOTHER'S MAIDEN NAME Aneda Battle | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 719-10-3442 | 17. INFORMANT Ida Mae Davis | | ADDRESS 708 GRANTLEY ST |
| 18. 445X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) Malignant Hypertension DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 14 hours unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from February 1 19 65 to February 2 19 65 , that (I) was last saw the deceased alive on February 2 19 65 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE Harry M. Charkatz | | | | 23B. DATE SIGNED 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) Harry M. Charkatz | | 23D. ADDRESS M.D. Sinai Hospital of Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/7/65 | 24C. NAME OF CEMETERY or CREMATORY DAVIS | | 24D. LOCATION (City, town, or county) (State) GRINGSLAND - N. C. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Jackson, M.D. | | 25C. FUNERAL DIRECTOR Charles A. Rice | |
| | | | | ADDRESS 661 W. BARNES ST | |

Mr. J. M. [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible]

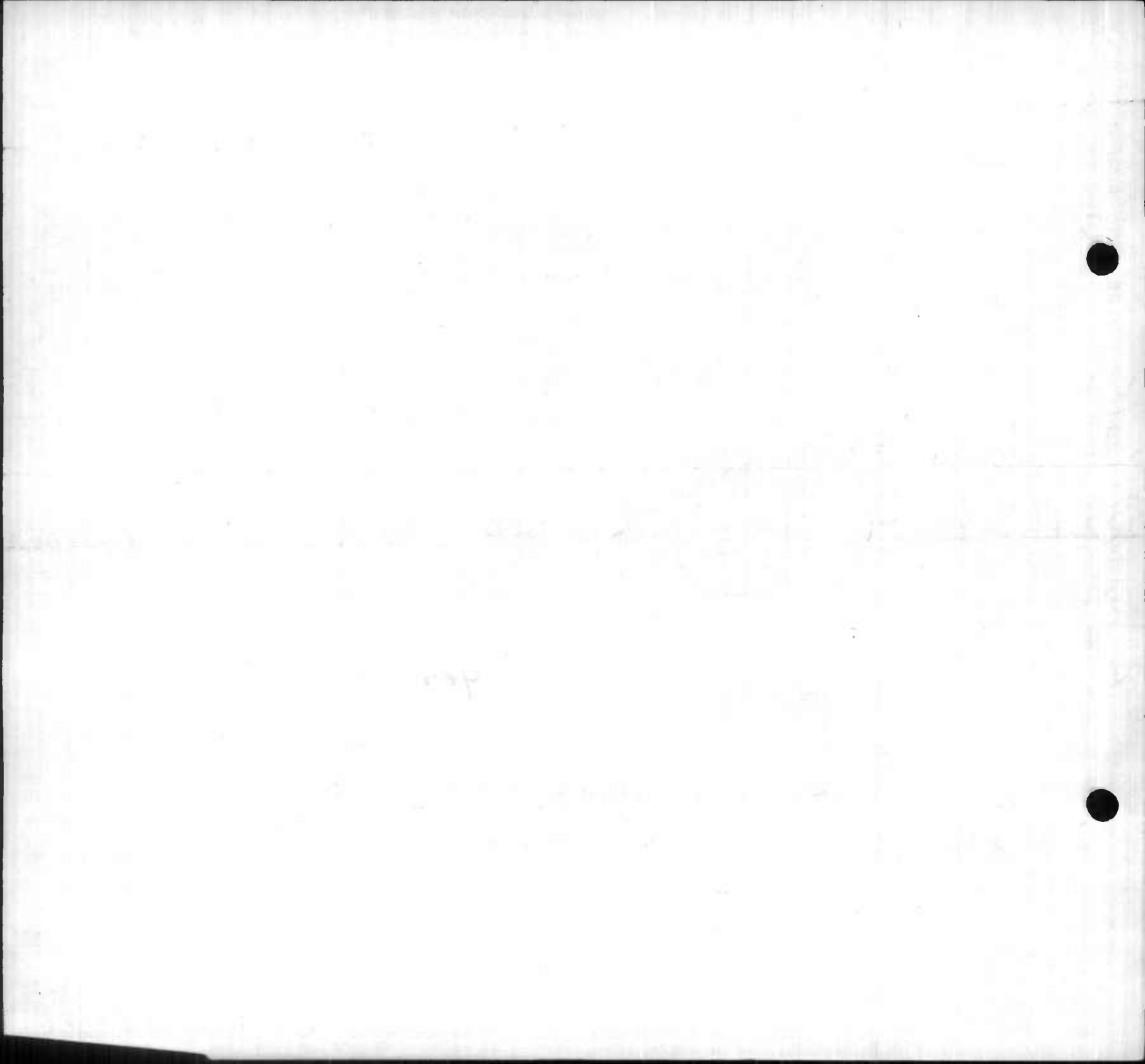
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

Henry M. [illegible]
Henry M. [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1271</u> | |
|---|---------------------|---|--|--|--|--|--|--|--|
| BIRTH NO. <u>65 1271</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Hall, Lillie B.</u> | | 2. DATE AND HOUR OF DEATH <u>2-1-65</u> <u>1:30 P</u> M. | | | |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>AA</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Odenton</u> | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>Box 275-B</u> | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u> | | 8. DATE OF BIRTH <u>6-29-1916</u> | | 9. AGE (In years last birthday) <u>48</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Archer C. Dorsey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eugenia Belt</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 6. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Joseph Butt (cousin) Odenton, Md.</u> | | | |
| 18. <u>570.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Profound Shock</u> | | | | CAUSE OF DEATH (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH <u>? 2 days</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO <u>Small Bowel Obstruction</u> | | | | <u>? 2 days</u> | |
| (C) DUE TO | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>N</u> (this hospital) attended the deceased from <u>1-31</u> 19 <u>65</u> to <u>2-1</u> 19 <u>65</u> , that <u>W</u> (we) last saw the deceased alive on <u>2-1</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>N</u> (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>D. Bernard Pleet</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2-1-65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>A. Bernard Pleet</u> | | | | 23D. ADDRESS <u>University Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-5-65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>North Tabor</u> | | 24D. LOCATION (City, town, or county) (State) <u>Chesterfield Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 4 1965</u> | | 25B. NAME OF REGISTRAR <u>W. E. Farley M.D.</u> | | 25C. FUNERAL DIRECTOR <u>William Reese</u> | | ADDRESS <u>Anna M.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

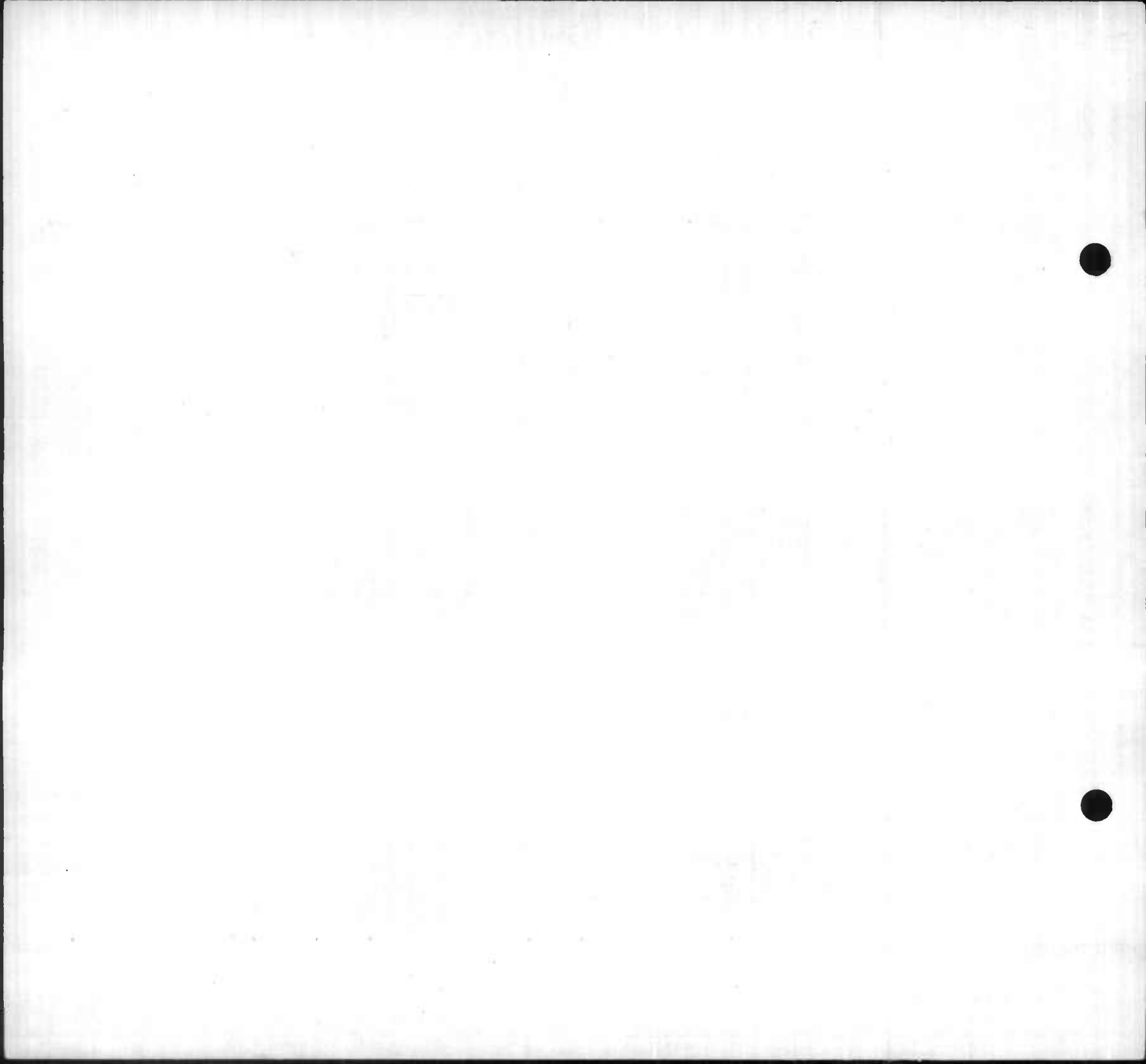
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|---|----------------------|--|--|--|--------------------------------------|--|--|--|--|--|
| BIRTH NO. 65 1272 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1272 | | | | |
| 1. NAME OF DECEASED (Type or Print) MYRTLE KAUFMAN | | | | | | | | | | 2. DATE AND HOUR OF DEATH 2/2/65 9 ¹⁵ P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-17 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 5313 HAMLIN AVE | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID | | 8. DATE OF BIRTH 2/5/1900 | | 9. AGE (In years last birthday) 64 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME Wm. F Reid | | | | | | 14. MOTHER'S/MAIDEN NAME KATHERINE SMITH | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS HOSPITAL ADMISSION RECORD | | | | | | | | |
| 18. 443X-4322.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Hypertensive arteriosclerotic heart disease (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ALCOHOLISM, LIVER DISEASE, UREMIA, urinary tract inf | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (he) (this hospital) attended the deceased from January 26 1965 to February 2 1965, that (I) (we) last saw the deceased alive on February 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Samuel M. Muher M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED February 2, 1965 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL MUHER | | | | | | 23D. ADDRESS SINAI HOSPITAL | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Nat | | | | 24D. LOCATION (City, town, or county) (State) Baltimore | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | | | 25C. FUNERAL DIRECTOR McElroy, 130 E Fourth St. | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

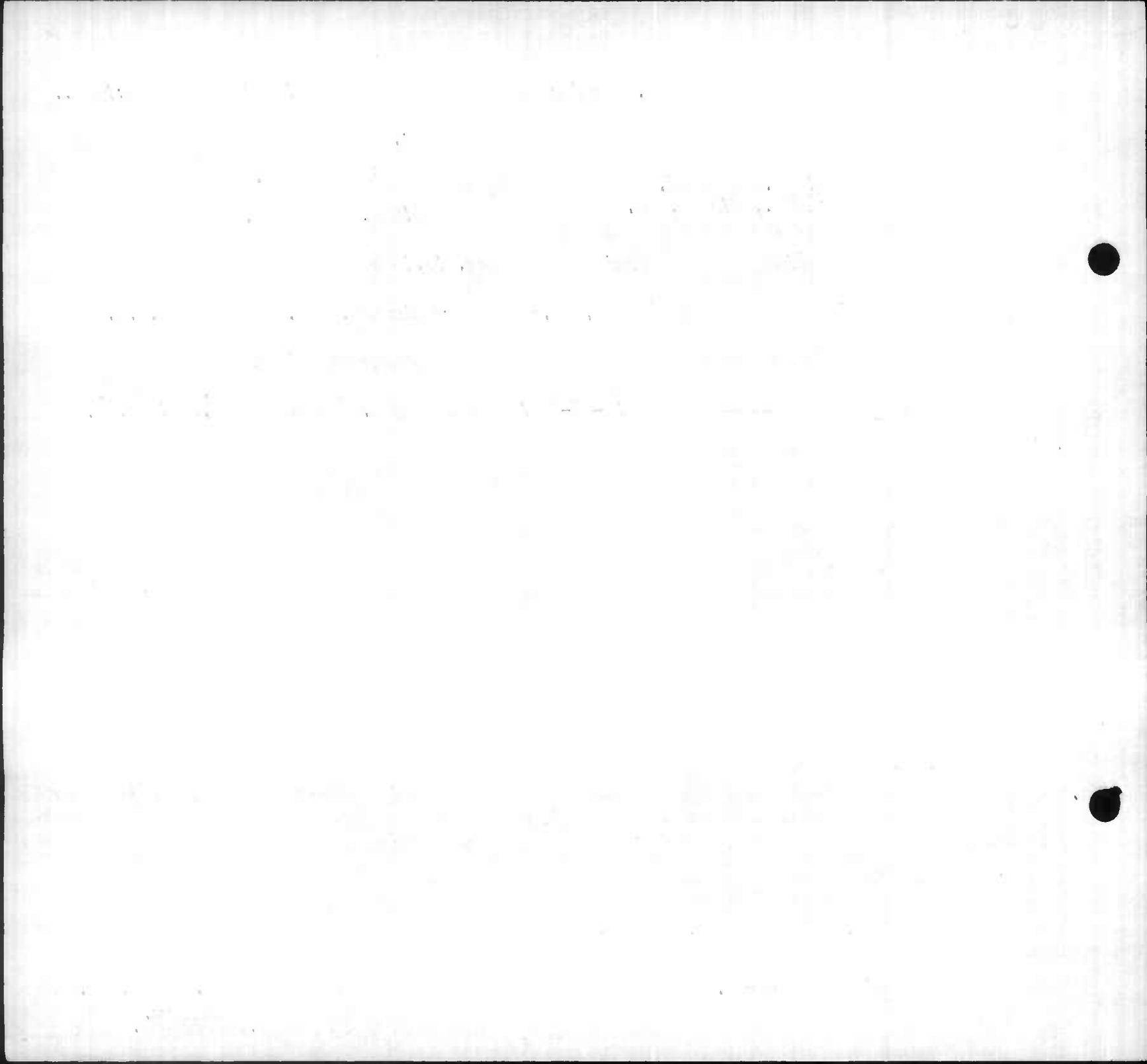
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. 65 1273 | | CERTIFICATE OF DEATH | | 65 1273 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Santa DiBlasi | | 2. DATE AND HOUR OF DEATH FEB. 3, 1965 16:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 | |
| FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp. | | D. STREET ADDRESS (If rural, give location) 408 E. Cross St. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 3-12-1885 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME George J. DiBlasi | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Family - Same | | ADDRESS |
| 18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 1-30 19 65 to 2-3 19 65 , that (we) last saw the deceased alive on 2-3 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Camilo G. Balacuit, Jr. M.D. | | | | 23B. DATE SIGNED 2-3-65 | |
| 23C. PHYSICIAN'S NAME (Type) CAMILO G. BALACUIT, JR. M.D. | | 23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St. | | | |
| 24A. BURIAL CEMETATION, REMOVAL (Specify) B | | 24B. DATE 2/6/65 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town or county) Baltimore | | 24E. NAME OF REGISTRAR Robert E. Farley | | 24F. FUNERAL DIRECTOR 1600 E. 130 E. Ford Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

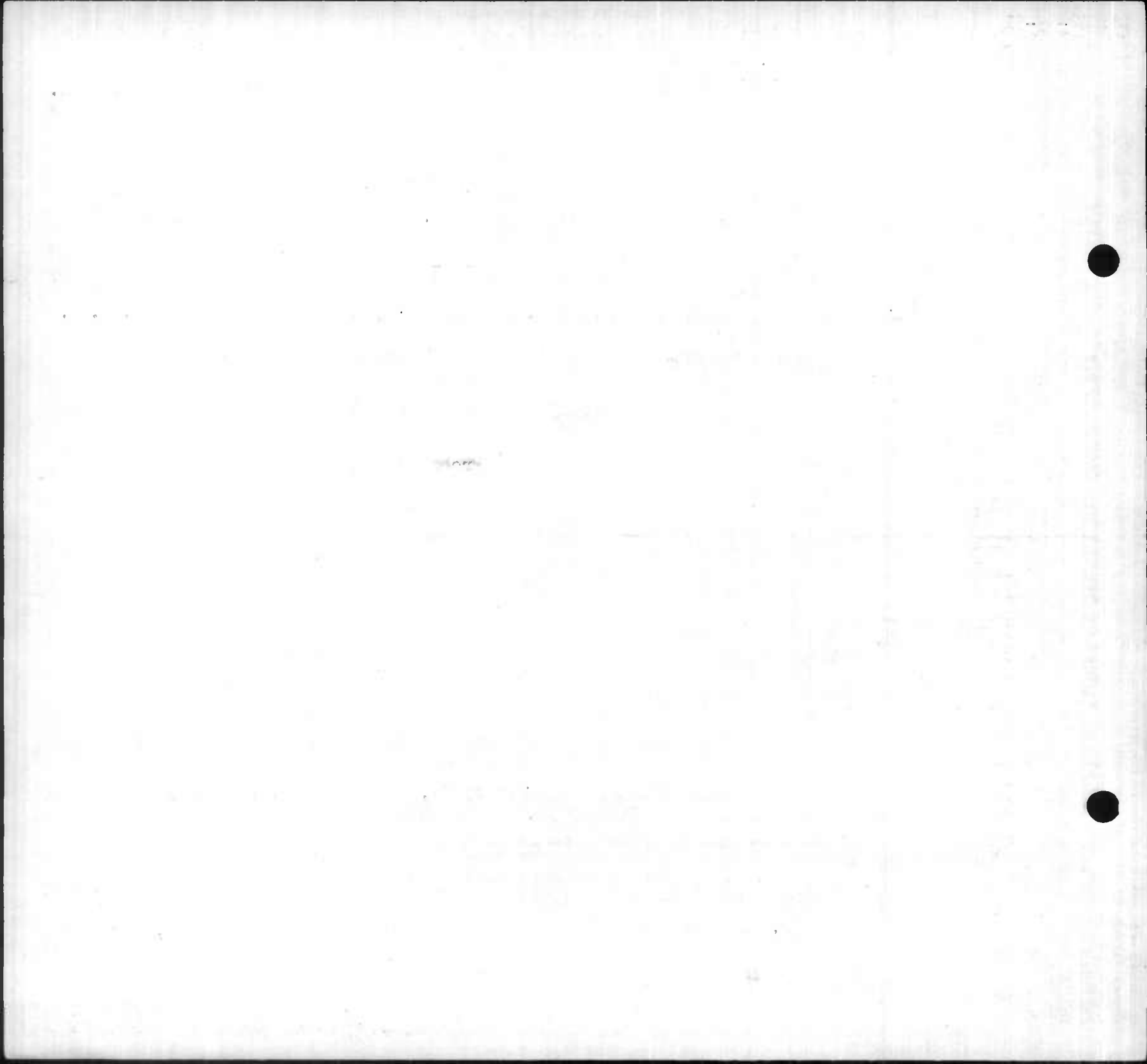
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|---|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1274 | | | | |
| BIRTH NO. 65 1274 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Robert H. Sauter | | | | | 2. DATE AND HOUR OF DEATH January 31, 1965 6:15 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 619 S. Macon St. Balto., 21224, Md. | | | | | A. STATE Md. | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 24. | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 619 S. Macon St. | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH Dec. 12, 1884 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY Baugh Chem. Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Sauter | | | | | 14. MOTHER'S MAIDEN NAME Margaret Reider | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-05-8331 | | 17. INFORMANT Margaret A. Sauter | | | ADDRESS 619 S. Macon St. Balto., 21224, Md. | |
| 18. 204.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Chronic myelogenous leukemia DUE TO | | | | |
| | | | | | (B) _____ DUE TO | | | | |
| | | | | | (C) _____ DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/15 1949 to 1/31 1965, that (I) (we) last saw the deceased alive on 1/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 2/2/65 | |
| 23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN | | | | | 23D. ADDRESS 5211 Hanford Rd Baltimore, Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-65. | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | | 24D. LOCATION (City, town, or county) (State) 3310 Taylor Ave. Balto. Co., MD. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Charles S. Jellier ADDRESS 6224 Eastern Ave. Balto., 21224, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1275 | |
|---|------------------|---|--|---|---|
| BIRTH NO. 65 1275 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) William A. Smith | | | 2. DATE AND HOUR OF DEATH January 31, 1965 2:30 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 911 S. Highland Avenue 21224 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3-19-88 | 9. AGE (In years last birthday) 76 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY POLICE | | 11. BIRTHPLACE (State or foreign country) Maryland BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME JOHN SMITH | | |
| 14. MOTHER'S MAIDEN NAME SUZANNE BOZMAN. | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 212-32-2540 | | | 17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable Myocardial Infarction | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 25, 19 65 to January 31, 19 65, that (I) (we) last saw the deceased alive on January 31, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard Lane | | | 23B. DATE SIGNED January 31, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Richard Lane | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-4-65 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM. | |
| 24D. LOCATION (City, town, or county) (State) BALTO. CO., MD. | | 24E. 7225 EASTERN BLVD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Charles J. Zeiler | |
| 25D. ADDRESS 901 S. CONKLING ST. | | BALTO., 21224, MD. | | | |

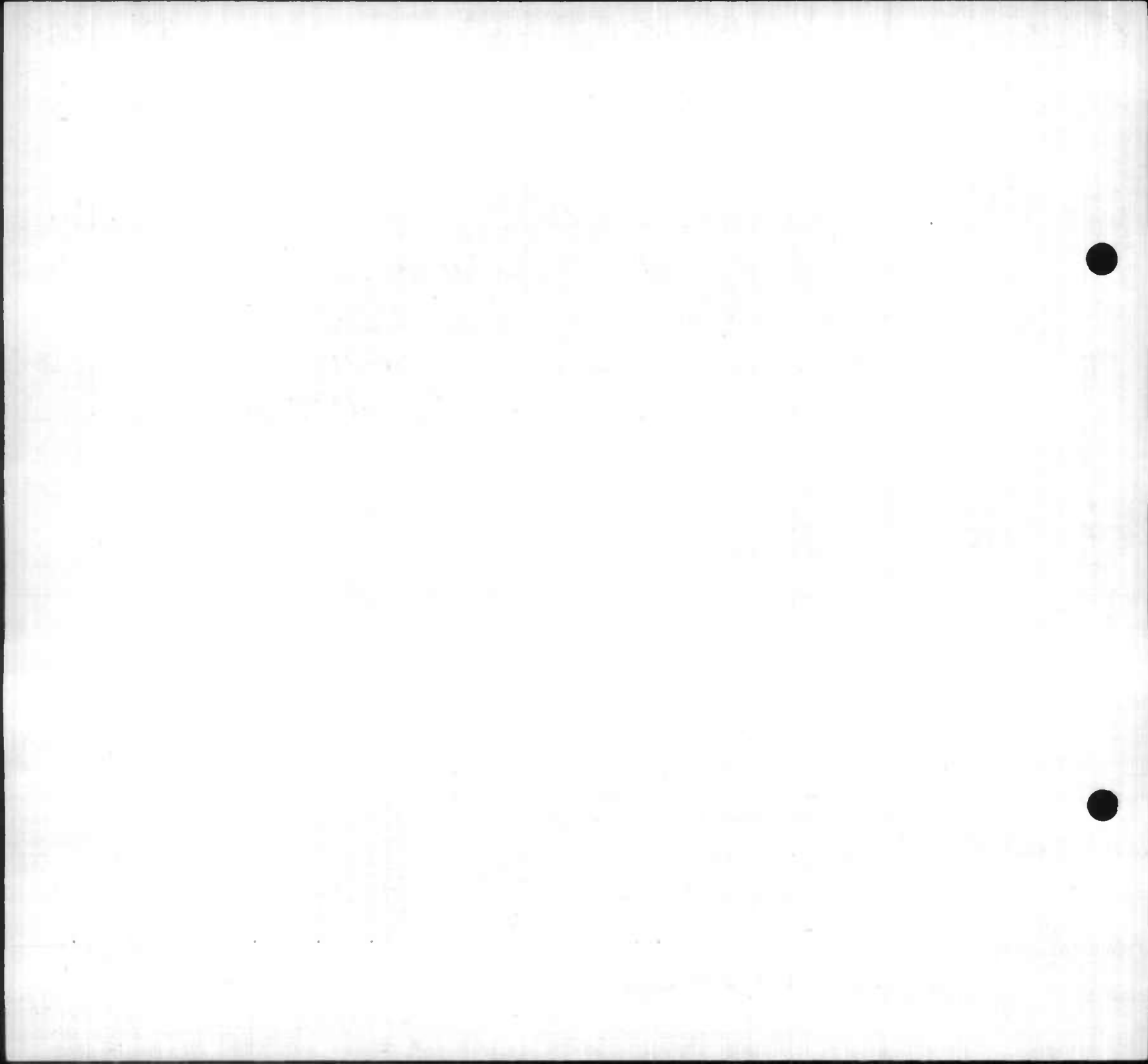


K. 5301

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

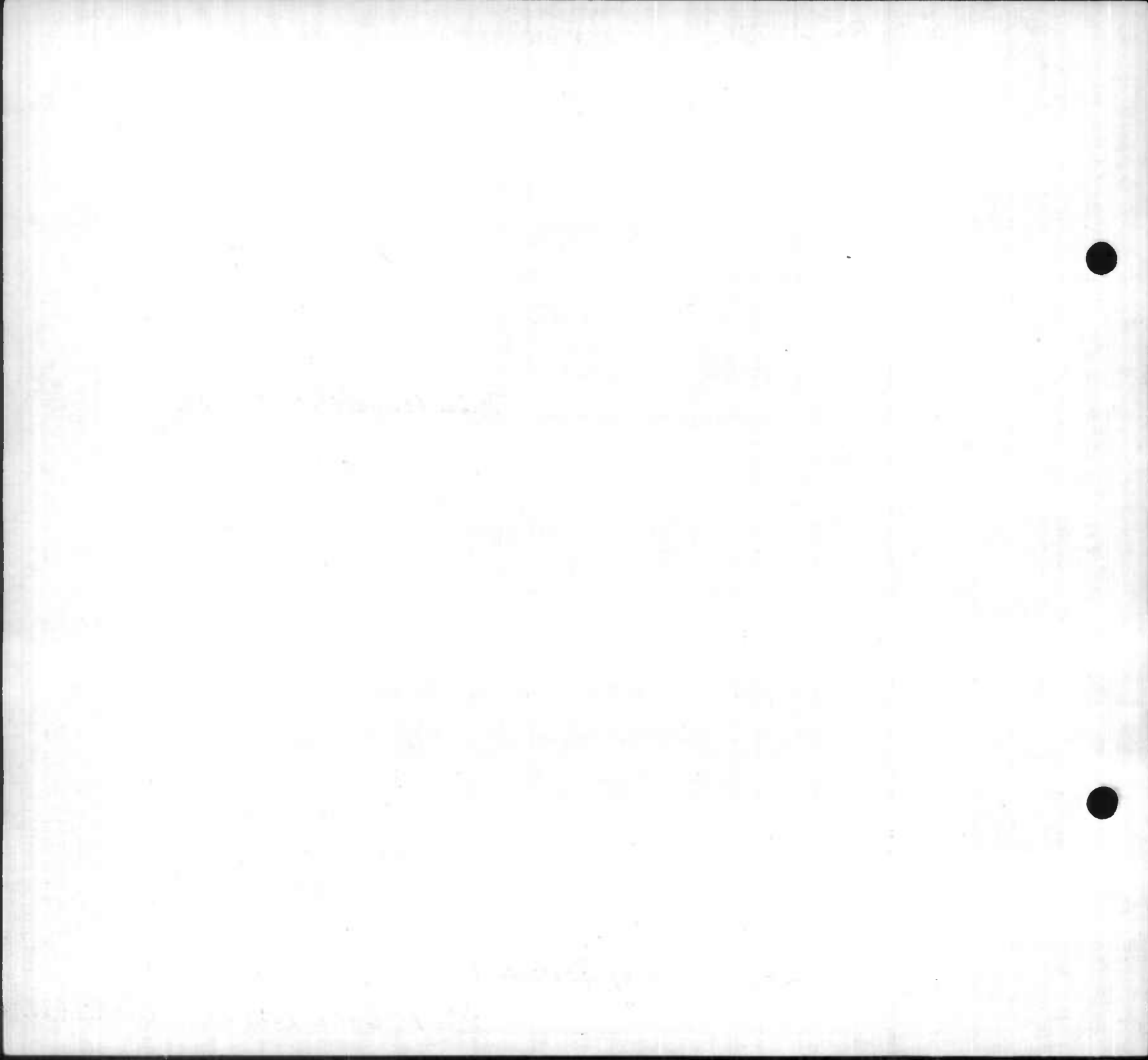
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1276 | |
|--|---------------|--|---|--|--|
| BIRTH NO. 45-02312 65 1276 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH Feb. 2, 1965 3:00 A.M. | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Kennedy | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 21-02 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp. | | D. STREET ADDRESS (If rural, give location) 812 Washington Blvd | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N.B. | 8. DATE OF BIRTH 2-2-65 | 9. AGE (In years last birthday) N.B. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10B. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (State or foreign country) Balto., Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Emanuel Kennedy | | 14. MOTHER'S MAIDEN NAME Shirley Hall | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Emanuel F. Kennedy | | ADDRESS above | |
| 18. 776x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Remotely DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 2-2 19 65 to 2-2 19 65, that (we) lost saw the deceased alive on 2-2 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John Weagly | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN WEAGLY, M.D. | | 23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/13/65 | | 24C. NAME OF CEMETERY or CREMATORY London Park Cem. | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Parker M.D. | | 25C. FUNERAL DIRECTOR John J. Cavanagh & Son Inc | | ADDRESS 13, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

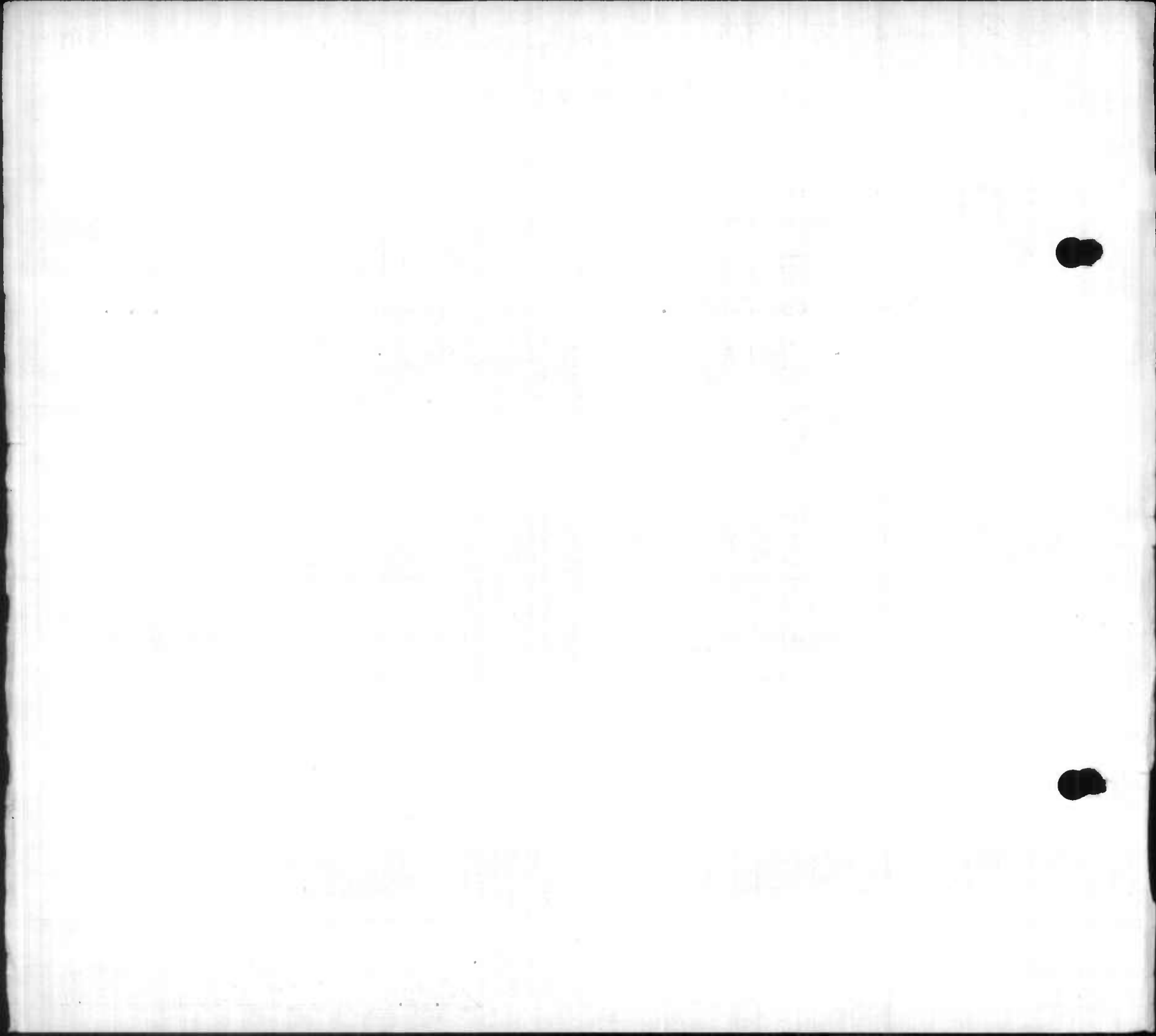
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|---------------------|---|--|--|--|--|--|--|--|-----------------------------|--|
| BIRTH NO. 65 1277 | | PAZNERAS | | Registered No. 65 1277 | | | | | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph A. Pazneras | | | | 2 Feb 1965 | | | | 11:30 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | A. STATE Maryland | | | | B. COUNTY 4-02 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 912 W. 7th St | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 12/8/07 | | 9. AGE (In years last birthday) 57 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Sales NOVELTY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Adam Pazneras | | | | 14. MOTHER'S MAIDEN NAME Agatha Kalinauskas | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Veteran | | | | 16. SOCIAL SECURITY NO. ✓ | | 17. INFORMANT Miss Annabelle Pazneras Pelham | | ADDRESS 2235 Ave | | | |
| 18. 331X I | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Enter Cerebral Hemorrhage | | | | 9 Hrs | | | |
| | | | | (B) Hypertensive Cerebral Vascular Disease | | | | | | | |
| | | | | (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | 20A. AUTOPSY? (Yes or No) no | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2 Feb 4 pm 1965 to 2 Feb 10:30 pm 1965 , that (I) (we) last saw the deceased alive on 2 Feb 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John Eckholdt | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 2 Feb 65 | | | |
| 23C. PHYSICIAN'S NAME (Type) John Eckholdt | | | | 23D. ADDRESS Univ Hospital Baltimore | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/6/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Parker M.D. | | 25C. FUNERAL DIRECTOR John J. Chavara, Inc. | | ADDRESS Baltimore, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

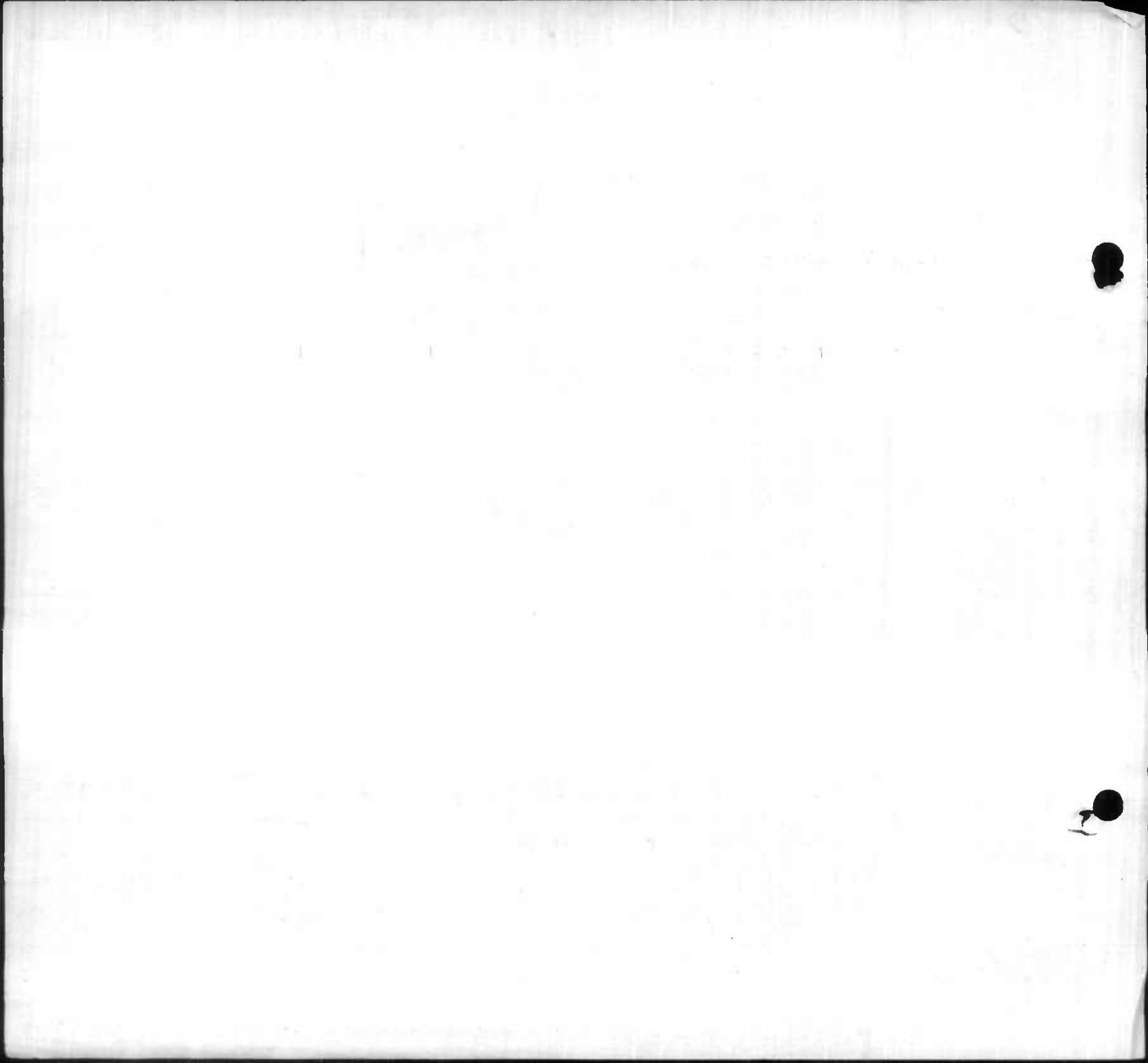
| CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 65 1278 | | CERTIFICATE OF DEATH | | Registered No. 65 1278 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JEANNETTA M. FILES | | 2. DATE AND HOUR OF DEATH 1-30-65 5:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21204 53-00 D. STREET ADDRESS (If rural, give location) 1674 Thetford Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 16, 1909 | 9. AGE (In years last birthday) 55 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Key-Punch Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Md. State Police | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John F. Tennyson | | | |
| 14. MOTHER'S MAIDEN NAME Olivia C. Callis | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212-10-3433 | | 17. INFORMANT ADDRESS Miss. Ellen Files 1674 Thetford R | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 570.2 I Mesenteric Thrombosis 2 days | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dawn Nichols | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/2/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Wm. E. Johnson 8521 Loch Raven Bl | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1279</u> | |
|--|-------------------------|---|-------------------------------------|--|---|---|---|
| BIRTH NO. <u>65 1279</u> | | M.E. CASE NO. <u>65 1279</u> | | 1. NAME OF DECEASED (Type or Print) <u>Darsey Keckley</u> | | 2. DATE AND HOUR OF DEATH <u>1/30/65</u> <u>7:50 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hosp.</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Md.</u> B. COUNTY <u>Balt.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balt.</u> | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>7807 Wilson Ave</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>06-09-89</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>JAMES SHINGLETON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH HAINES</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| 18. <u>157X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <u>Cardiopulmonary arrest</u> DUE TO | | | |
| | | | | (B) <u>Cardiac arrest</u> DUE TO | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>3/1/25/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory Lap</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., on or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>01-19-65</u> 19 <u>65</u> to <u>1/30</u> 19 <u>65</u> , that <u>he</u> (we) last saw the deceased alive on <u>1/30</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>H. Azar</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/30/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>H. AZAR</u> | | | | 23D. ADDRESS <u>Johns Hopkins Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1/2/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>EBENEZER CEM.</u> | | 24D. LOCATION (City, town, or county) (State) <u>ROMNEY West. Va.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 4 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u> | | 25C. FUNERAL DIRECTOR <u>William E. Johnson</u> | | ADDRESS <u>521 Oak Park</u> | |



FUNERAL DIRECTOR: IMPORTANT

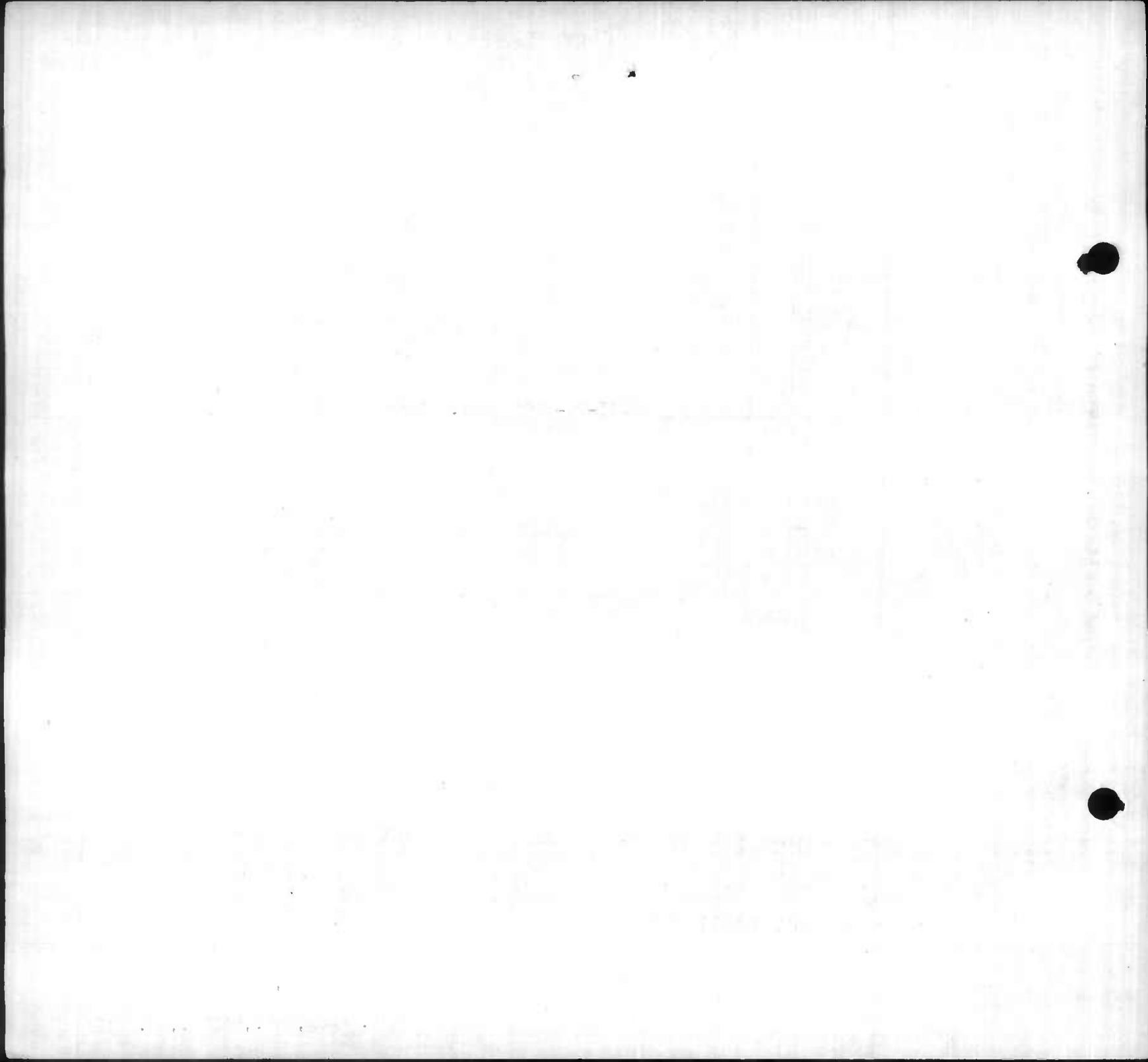
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | Registered No. <u>65 1280</u> | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. <u>65 1280</u> | | NAME OF DECEASED <u>LAYFIELD, HENRY A.</u> | | | | DATE AND HOUR OF DEATH <u>2-1-65 10:35P</u> | |
| M.E. CASE NO. | | PLACE OF DEATH IN BALTIMORE, MARYLAND <u>ST. AGNES HOSPITAL</u> | | | | USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO. CO.</u> | |
| 1. NAME OF DECEASED (Type or Print) | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>ST. AGNES HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO. CO.</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> | | 5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | | | 8. DATE OF BIRTH <u>2-25-92-1893</u> 9. AGE (In years last birthday) <u>72 71</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>PENNSYLVANIA R.R.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>HENRY A. Layfield-Layfield</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sadie SARAH LLOYD</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR 1</u> | | 16. SOCIAL SECURITY NO. <u>717-07,7683</u> | | 17. INFORMANT <u>WILKENS AVE. #29 ST. AGNES HOSPITAL RECORDS; CATON &</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CEREBRAL THROMBOSIS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HYPERTENSION</u> | | | | | | YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 31 19 65</u> to <u>FEBRUARY 1 19 65</u> , that (I) (we) lost saw the deceased alive on <u>FEBRUARY 1 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Richard Kelly M.D.</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2-1-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICHARD J KELLY M.D.</u> | | | | 23D. ADDRESS <u>ST. AGNES HOSPITAL; CATON & WILKENS AVE. #29</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/5/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>LORRAINE</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 4 1965</u> | | 25B. NAME OF REGISTRAR <u>Club E. Fisher M.D.</u> | | 25C. FUNERAL DIRECTOR <u>E. S. MACNABB</u> | | ADDRESS <u>21228</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|---|---|
| BIRTH NO. 65 1281 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1281 | |
| 1. NAME OF DECEASED (Type or Print) Walter Edward Bandell, SR. | | | 2. DATE AND HOUR OF DEATH Feb 1, 1965 440 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2831 Forest View Ave 21214 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/16/10 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) repairman | | 10B. KIND OF BUSINESS OR INDUSTRY Police Force | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William W Bandell | | | 14. MOTHER'S MAIDEN NAME Katherine Link | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-09-3105 | 17. INFORMANT Mrs. Mildred Marie Bandell. | | ADDRESS Same |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Myocardial Infarction immediate DUE TO (B) Coronary Artery disease months DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/5/65 19 to 2/1/65 19, that (I) (we) last saw the deceased alive on 2/1/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE I. Frank Hartman II | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) I Frank Hartman II | | 23D. ADDRESS Univ. Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/6/65 | | 24C. NAME of CEMETERY or CREMATORY BALTIMORE CEMETERY | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214 | |



1
C-120

65 1282

BALTIMORE CITY HEALTH DEPARTMENT

65 1282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|-------------------------------------|---|---|---|----------------------------------|
| 1. NAME OF DECEASED (Type or Print) (JENNIE) GIOVANNINA CAPIZZI | | | | 2. DATE AND HOUR PRONOUNCED DEAD February 1, 1965 9:00 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2819 Harview Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-07 D. STREET ADDRESS (If rural, give location) 2819 Harview Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 3/9/1892 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY MEN'S TAILORING | | 11. BIRTHPLACE (State or foreign country) ITALY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ANTONINO CAPIZZI | | | | 14. MOTHER'S MAIDEN NAME GIUSEPPINA MARCHIAVAFA | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-03-6336 | | 17. INFORMANT ADDRESS MR. AGATINO CAPIZZI, 7900 Oakdale Ave. | | | |
| 18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John E. Adams</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-2-65 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 2/6/1965 | | 23C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEMETERY | | 23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK INC., BALTO., MD. 21214 | | | |

WALL BY FONGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

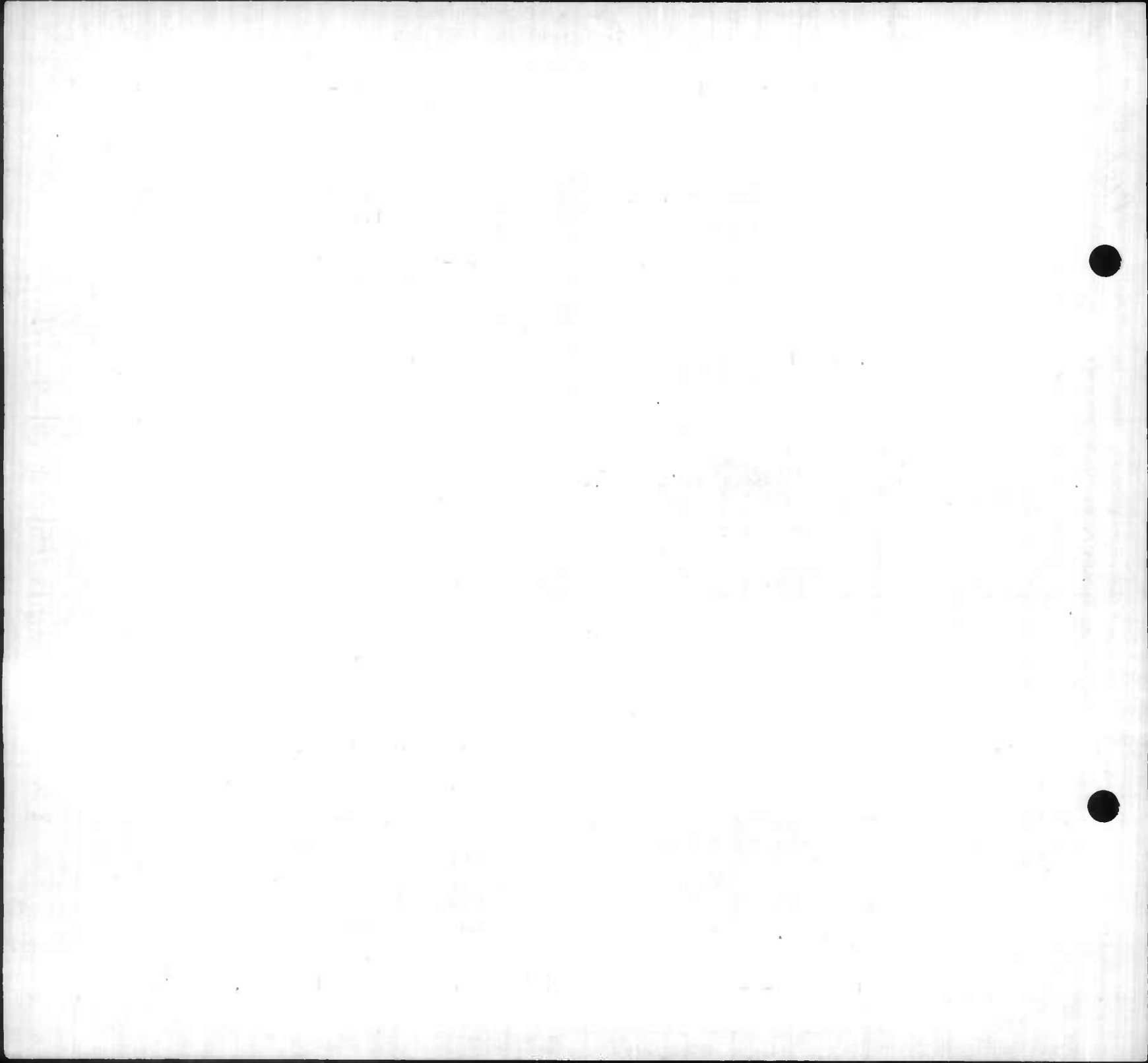
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 1283 | | Registered No. 65 1283 | |
|--|---------|--|------------------|--|----------------------------|--|--|
| M.E. CASE NO. | | | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Carl F. Day | | | | February 2, 1965 8:55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| South Baltimore General Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 1431 Battery Avenue Balto. 30, Md. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | |
| Male | White | Married | 10/1/98 | 66 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Truck Driver | | Plumbing | | Balto. Md. | | U S A | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Charles Day | | | | Margaret | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 216 05 9681 | | Mrs. Martha Day 1431 Battery Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| <p>5721 I</p> <p>ABSCCESS OF THE PELVIC CAVITY</p> <p>probably secondary to a ruptured diverticulitis of the sigmoid colon</p> | | | | <p>24 days</p> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 31-15-65 | | Abscess pelvic cavity | | yes | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from January 11 1965 to February 2 1965, that (X) (we) last saw the deceased alive on February 2 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| ESTEBAN FRIERA, M.D. | | | | | | 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| | | South Balto. Gen. Hosp. - 1213 Light St. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2 6 65 | | Holy Cross | | Brooklyn, A. A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 4 1965 | | Robert E. Fisher | | Mc Cully | | 130 E. Fort Ave | |

7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | 65 1284 | | | |
|--|--|---------------------|----------------------------|--|---|-----------------------------------|-----------------------|---|--|---|--|----------------------------------|--|
| BIRTH NO. 65-02864 | | | | | | | | | | 65 1284 | | | |
| M.E. CASE NO. | | | | | | | | | | Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY CAUDILL | | | | | 2. DATE AND HOUR OF DEATH 2-3-65 5:27AM M. | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOPPA D. STREET ADDRESS (If rural, give location) 258A WHITT ROAD | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD | | 8. DATE OF BIRTH 2-2-65 | | 9. AGE (In years last birthday) 6 | | 10. If Under 1 Yr. Months: Days 6 27 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| 13. FATHER'S NAME MACK F. CAUDILL | | | | | 14. MOTHER'S MAIDEN NAME PAULINE MELBER | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| 18. 770.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fetal anoxia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3ytrio blastosis fetalis | | | | | | | | | | CAUSE OF DEATH (A) Fetal anoxia DUE TO (B) 3ytrio blastosis fetalis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Promaturity | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10:50 PM 2/2/65 to 5:27 AM 2/3/65 , that (I) we lost saw the deceased alive on 2/3/65 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE Kenneth L. Jones | | | | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED 2/3/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) KENNETH L. JONES | | | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | | 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS HOSPITAL | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE 5, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS 65 1284 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

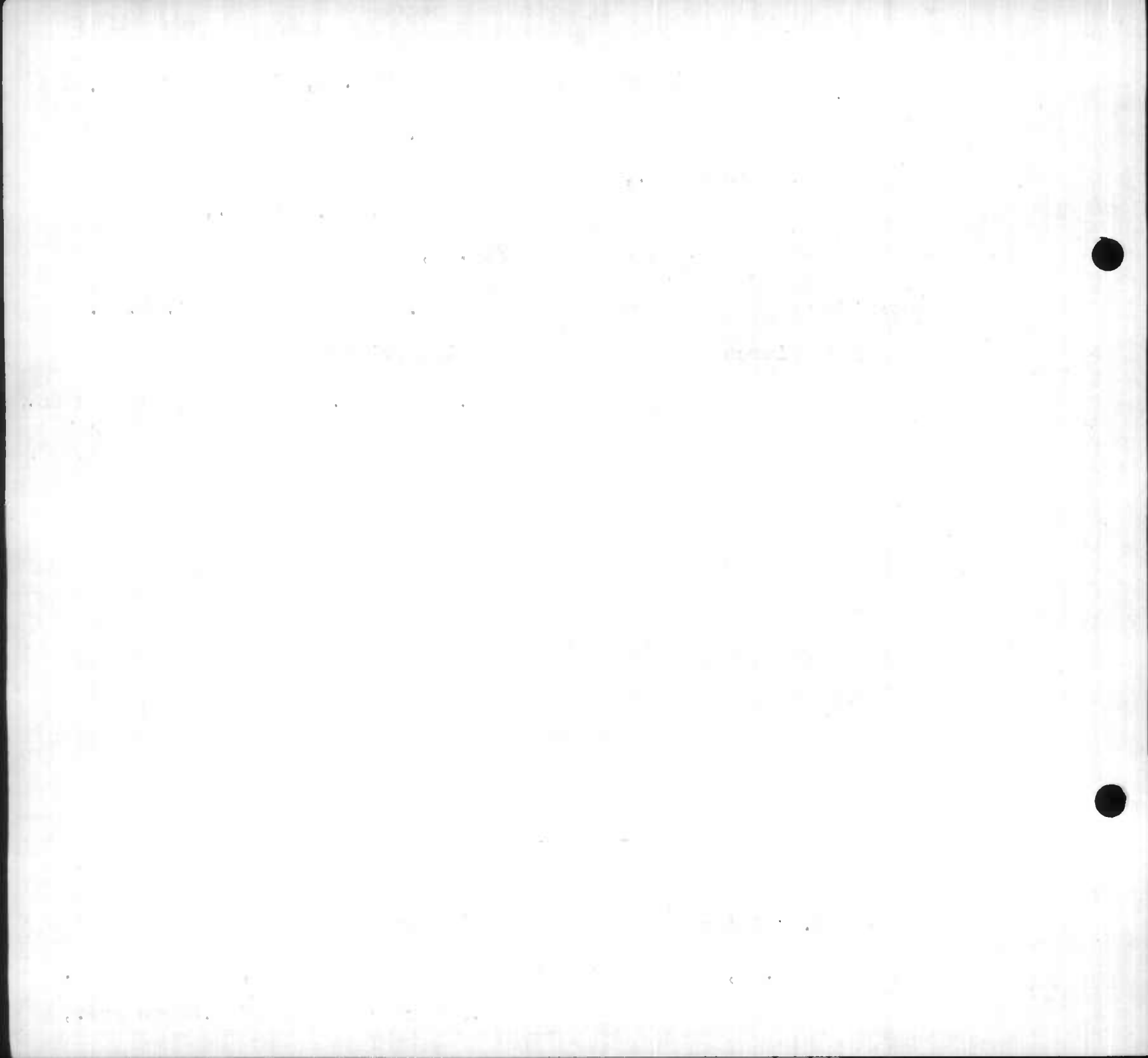
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|---------------------------|--|--|---|---|--|--|--|--|---|--|
| BIRTH NO. <i>Calvert Co., Md. 65 1285</i> | | | | | | CERTIFICATE OF DEATH | | | Registered No. <i>65 1285</i> | | |
| M.E. CASE NO. | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>WILLIAM HAWKINS</i> | | | | | | Feb 1, 1965 <i>802 P. M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>JOHNS HOPKINS HOSPITAL.</i> | | | | | | A. STATE <i>MARYLAND</i> | | | | | |
| | | | | | | B. COUNTY <i>Calvert</i> | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>LOWER MARIBORO.</i> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <i>54-00</i> | | | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>COLORED</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>CHILD</i> | | 8. DATE OF BIRTH <i>1-15-65</i> | 9. AGE (In years lost birthday) <i>17 DAYS</i> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>NORMAN HAWKINS</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>VIOLA NORMONT.</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| 18. <i>7640 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | CAUSE OF DEATH (A) <i>DEHYDRATION</i> DUE TO (B) <i>DIARRHEA</i> DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 1</i> 19 <i>65</i> to <i>Feb 1</i> 19 <i>65</i> , that (I) was lost saw the deceased alive on <i>Feb 1</i> 19 <i>65</i> and that in (my) was opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>James F. Mellinger</i> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>Feb 1, 1965</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. JAMES F. MELLINGER</i> | | | | | | 23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | | | |
| <i>CREMATION</i> | | <i>2-3-65</i> | | <i>JOHNS HOPKINS HOSPITAL</i> | | <i>BALTIMORE 5, MARYLAND</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 4 1965</i> | | | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR | | | ADDRESS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1286 | |
|--|---|---|--|---|---|
| BIRTH NO. 65 1286 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Irona May Fisher | | 2. DATE AND HOUR OF DEATH Feb. 2, 1965 1.10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1140 W. Hamburg St., | | A. STATE Md. B. COUNTY 21-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 1140 W. Hamburg St., | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Feb. 15, 1875 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Emmanuel Pierce | | 14. MOTHER'S MAIDEN NAME Alice Triplett | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Burdell H. Shaw 1140 W. Hamburg St., | |
| 18. 290.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Sensitivity DUE TO (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pernicious Anemia | | INTERVAL BETWEEN ONSET AND DEATH 540 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1946 19 to 2/2/65 19, that (I) (we) last saw the deceased alive on 2/2/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. S. Kallins M.D. | | | | 23B. DATE SIGNED 2/3/65 | |
| 23C. PHYSICIAN'S NAME (Type) Edward S. Kallins | | | | 23D. ADDRESS Ep 300 Liberty St. Dr. Backus | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Feb. 5, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill | |
| 24D. LOCATION Brooklyn, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | |
| 25C. FUNERAL DIRECTOR G. Howard Strong | | 25D. ADDRESS 3207 W. North Ave., | | | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Rpy Scott

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 30, 1965

7:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2042 Eutaw Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2042 Eutaw Place

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SEPARATED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

765

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
256-07-522517. INFORMANT
ADDRESS
MRS MARY E. ROSS 2619 Loyola NORTHWAY

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
Jan. 31, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/5/65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetry

23D. LOCATION (City, town, or county) (State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 4 1965

Adolphus Halstead 918 Druid Hill Ave

WALLLEY T. 100015

T-656

65 1288

BALTIMORE CITY HEALTH DEPARTMENT

65 1288

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES TURNER

2. DATE AND HOUR PRONOUNCED DEAD

1-24-65

8:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1145 E. Lombard Street - 21202

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
separated

8. DATE OF BIRTH

9. AGE (In years last birthday)

32

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Lucille

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
yes

WW 2

16. SOCIAL SECURITY NO.
228-28-7334

17. INFORMANT

ADDRESS

Mrs Mary E Lucas 1819 W Lexington St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral injuries with right subdural hematoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

West Fallsway and Water Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute)
1 24 1965 4:00 PM

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck in head with board

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-25-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

2/5/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

1756 FEB 4 1965

Robert E. Farley, M.D.

Adolphus Halstead 918 Druid Hill Ave

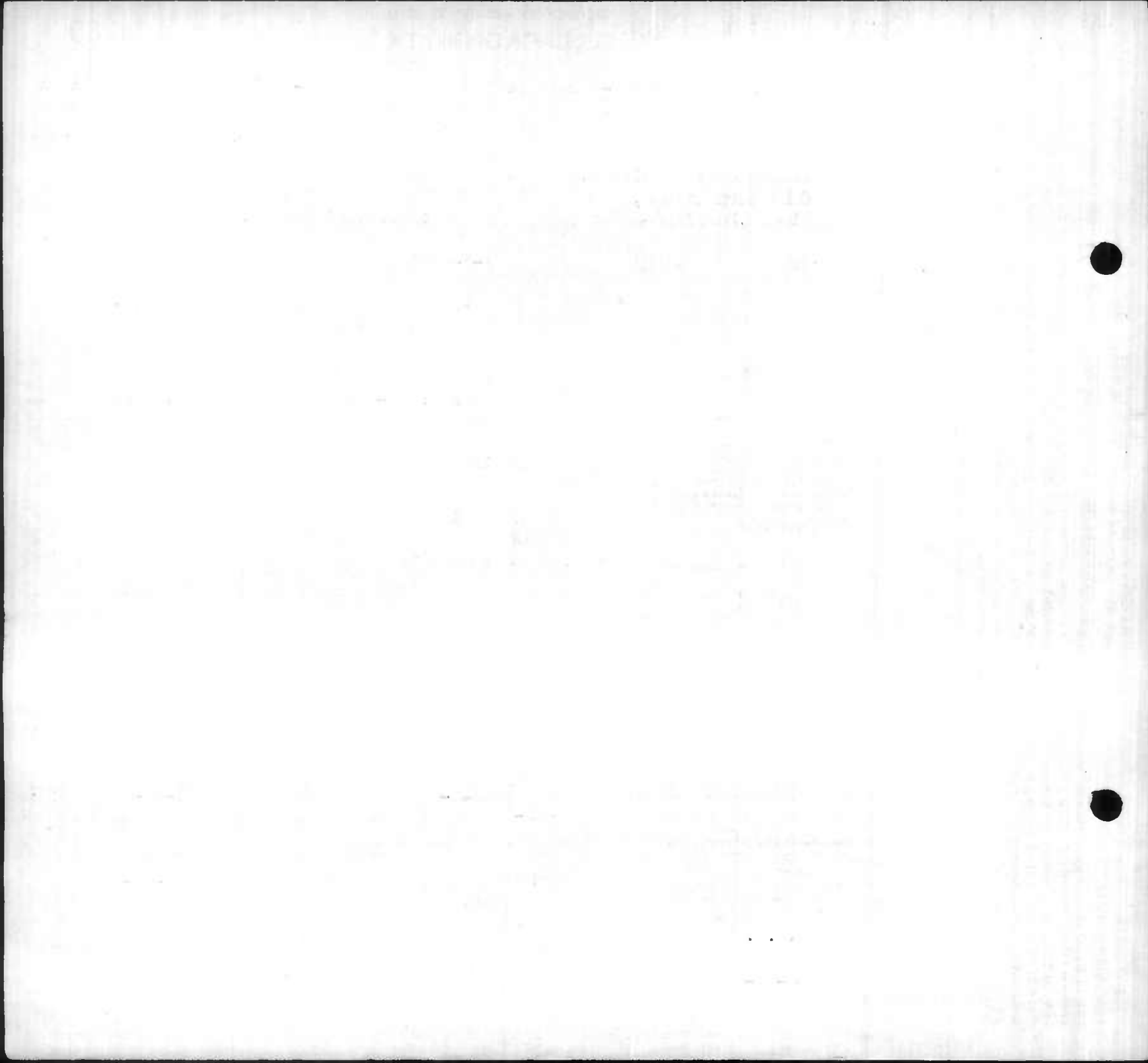
VALLEY FOLDER



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1289 | |
|---|--|---|---|--|--|
| BIRTH NO. 6500100 | | 65 1289 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Baker-Geraldine | | | 1-24-1965 1 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland-21224 | | | A. STATE Maryland B. COUNTY 5-81 | | |
| 5. SEX Female | | | 6. RACE Negro | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | | 8. DATE OF BIRTH 1-5-1965 | | |
| 9. AGE (In years last birthday) | | | 10. AGE (In years last birthday) | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME Geraldine | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Records: BCH-4940 Eastern Avenue, 21224 | | | ADDRESS | | |
| 18. 7635 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia Prematurity | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-5-1965 to 1-24-1965 , that (I) (we) last saw the deceased alive on 1-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED 1-24-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. S.W. Klein | | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE 1-26-1965 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS | |



CERTIFICATE OF DEATH

Registered No.

65 1290 4

BIRTH NO.

65-00284

65

1290

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Willis, Baby Girl, Atlanta

2. DATE AND HOUR OF DEATH

1-8-65

9:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

436 East 22nd. Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1-8-65

9. AGE (In years
last birthday)If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.

2 1/2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue 21224

18. 762.5 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral Anoxia
DUE TO

ANTECEDENT CAUSES

(B) Prematurity
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-8-1965 to 1-8-1965,
that (I) (we) last saw the deceased alive on 1-8-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S Wayne Klein

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-8-65

23C. PHYSICIAN'S
NAME (Type)

Dr. S. Wayne Klein

M.D.

23D. ADDRESS

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Cremated

1-15-1965

Baltimore City Hospitals

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

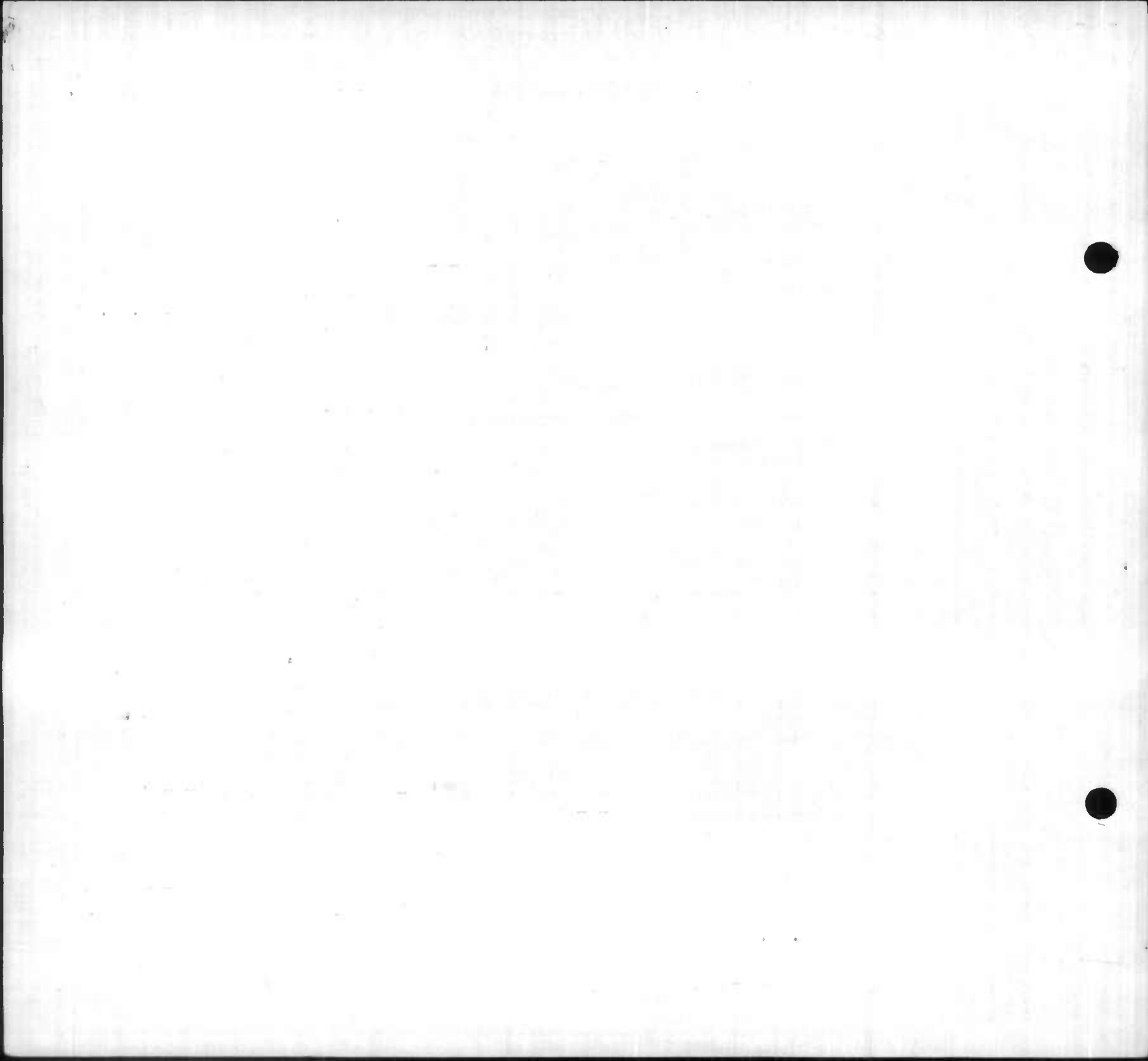
FEB 4 1965

Robert E. Taylor, M.D.

0 1 2 2 1

FUNERAL DIRECTOR: IMPORTANT

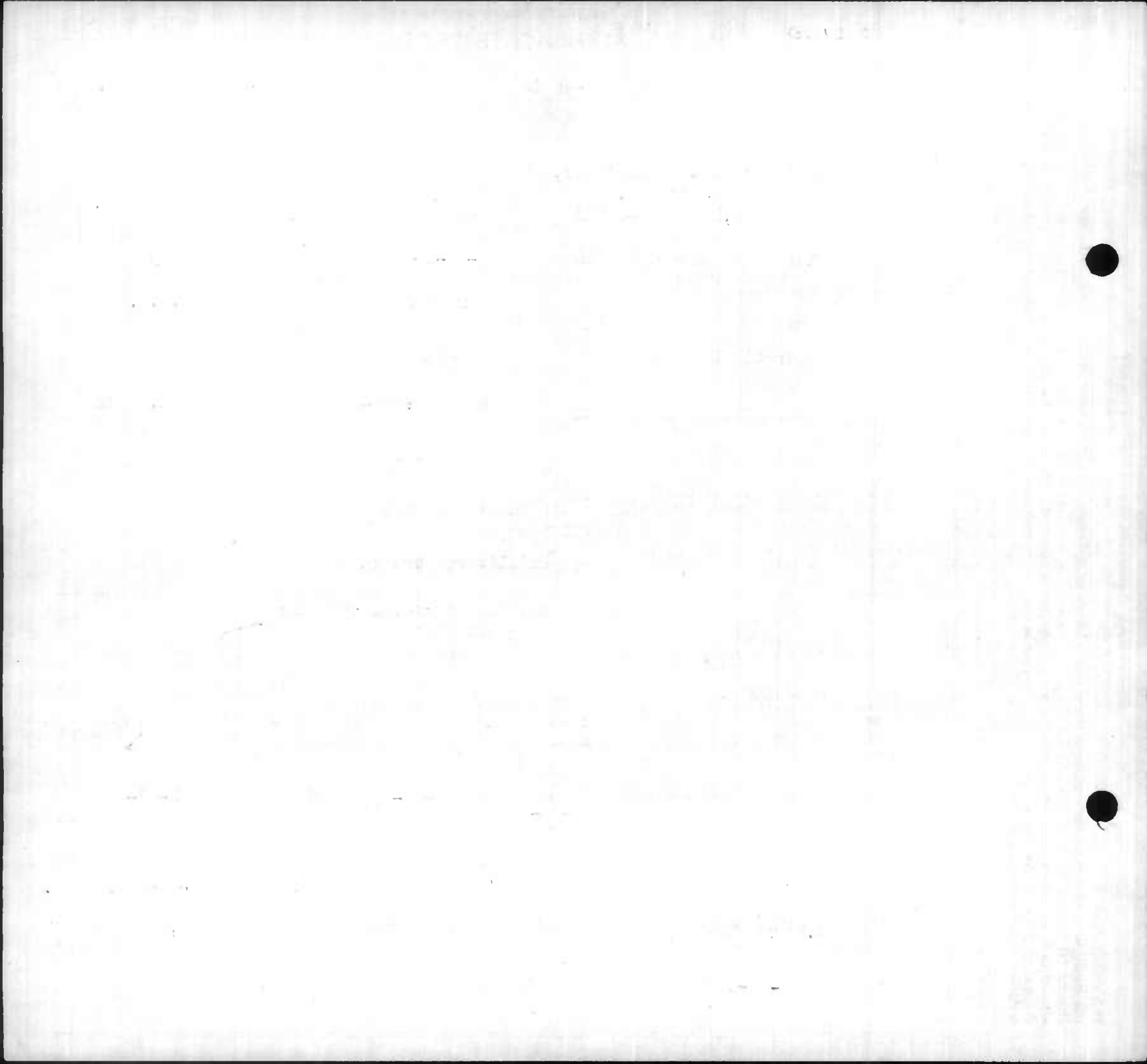
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

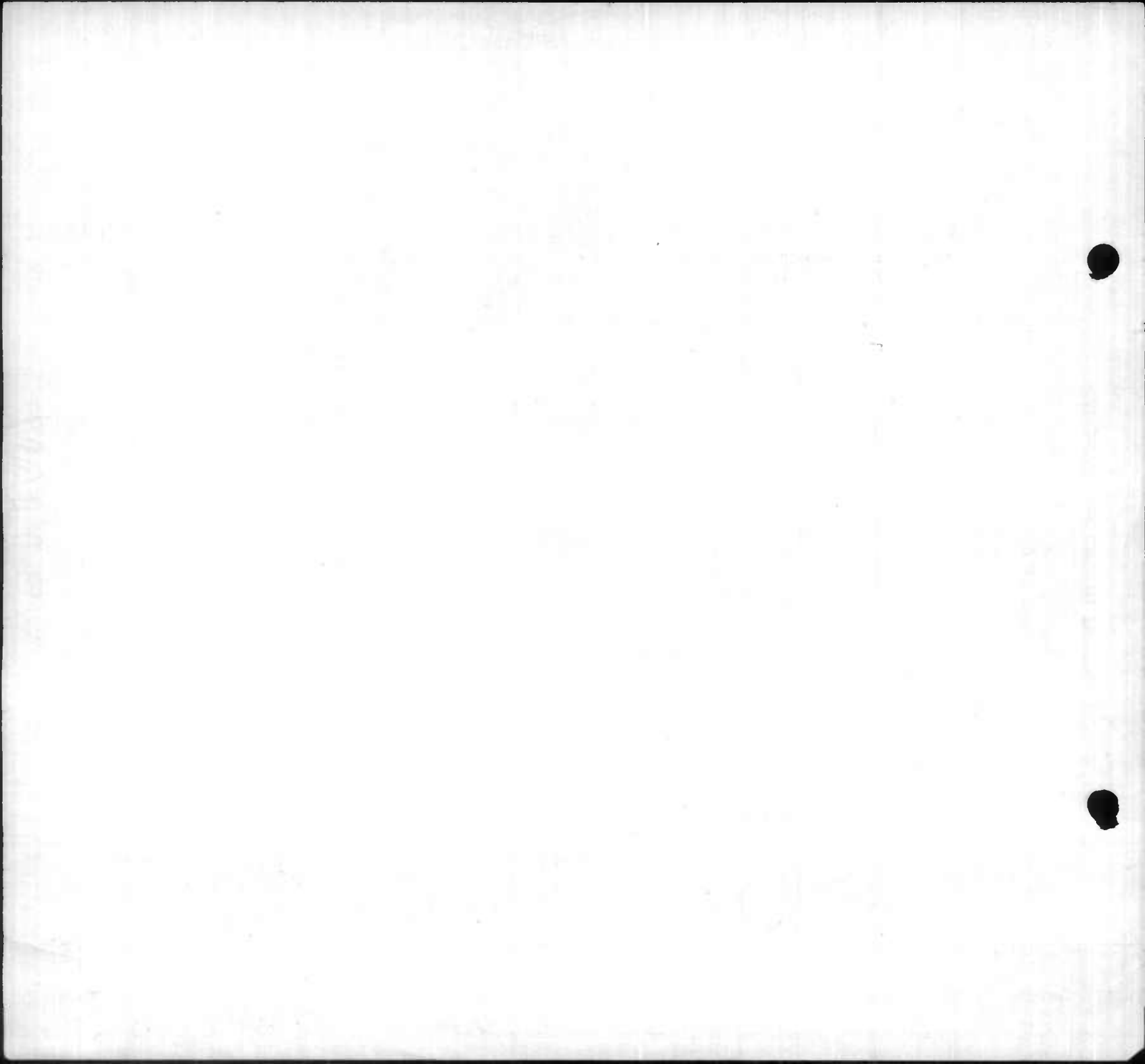
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---|--|---|---|--|--|---|---|---------|--|
| BIRTH NO. 65-01110 65 1291 CERTIFICATE OF DEATH | | | | | Registered No. 65 1291 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Burgess-Janie | | | | | 2. DATE AND HOUR OF DEATH 1-23-1965 6.20 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland-21224 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7509 Lange Street, 21224 | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | | 8. DATE OF BIRTH 1-20-1965 | 9. AGE (In years last birthday) 3 | If Under 1 Yr. Months: Days: Hours: Min. 3 | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Carroll Burgess | | | | | 14. MOTHER'S MAIDEN NAME Janie | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue, 21224 | | | | | |
| 18. 7610 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Anoxia Asphyxia Undelivered Breech | | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | |
| 19. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mother has Paraplegia, Labor pains not felt | | 20A. AUTOPSY? (Yes or No) Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-20-1965 to 1-23-1965 , that (I) (we) last saw the deceased alive on 1-23-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE S Wayne Klein | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1-23-1965 | | |
| 23C. PHYSICIAN'S NAME (Type) S.Wayne Klein | | | | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE 1-26-1965 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR 2222 | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1292 | |
|--|---|---|--|--|--|
| BIRTH NO. 65 1292 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ANNA L. WELCH | | | 2. DATE AND HOUR OF DEATH FEB. 2, 1965 11:35 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL BALTIMORE 31, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 6-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 411 N. CASTLE ST. | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH SEPT. 19, 1913 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME BROOKS THOMAS | | | 14. MOTHER'S MAIDEN NAME GROSECLOSE MARTHA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 229-46-8018 | 17. INFORMANT ADDRESS Hospt Records | | |
| 18. I 171X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA, CERVIX, STAGE IV DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 12 1964 to FEB. 2 1965 , that (I) (we) last saw the deceased alive on FEB. 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel J. Tan | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Feb. 2, 1965 |
| 23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN | | | 23D. ADDRESS M.D. CHURCH HOME & HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE Feb 7, 1964 | 24C. NAME OF CEMETERY or CREMATORY GROSECLOSE Family Cem | 24D. LOCATION (City, town, or county) (State) BOSSEvain VA. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR Joseph X. Zannone Jr | | ADDRESS 263 S. Conkling St | |



G. 650

65 1293

BALTIMORE CITY HEALTH DEPARTMENT

65 1293

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AARON GREEN

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965

7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2413 Woodbrook Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 13, 1892

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Aaron Green Jr.

14. MOTHER'S MAIDEN NAME

Jennie Callahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-24-1851

17. INFORMANT

ADDRESS

Viola Green 2413 Woodbrook Ave.

18.

E904.61

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2-1-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Increased

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

club

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Women's club of Roland Park

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
2 1 65 A.

21E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE
AT WORK ☐21F. HOW DID INJURY OCCUR? Apparently fell while
shoveling snow at work 27-14

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-2-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/6/65

23C. NAME OF CEMETERY or CREMATORY

AK Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

Arbutus, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

N856.0 FEB 4 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

George A. Kelen 1348 N. Calhoun St.

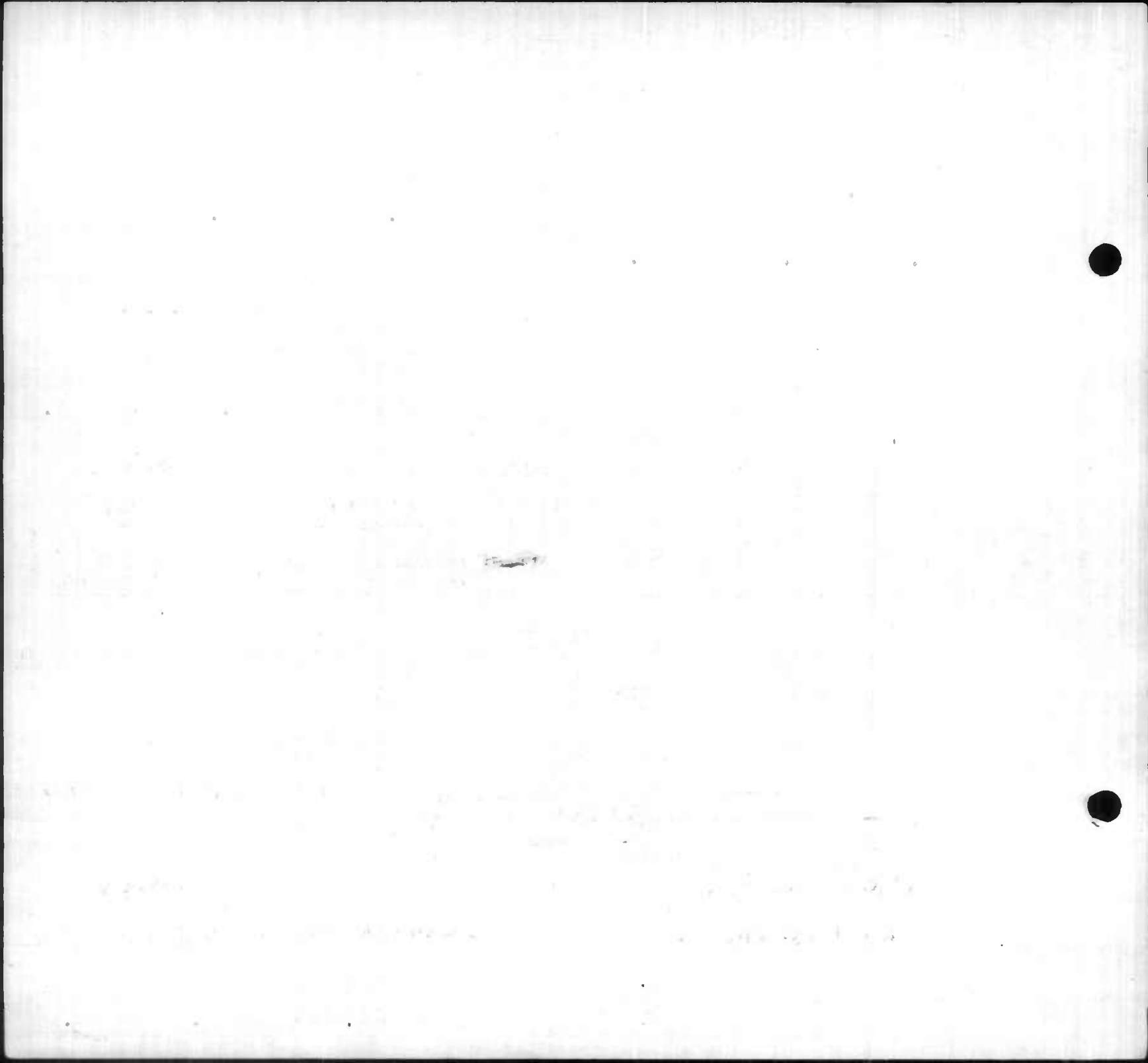
ADDRESS

WALSH & COMPANY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1294 | |
|--|----------------------|--|---|--|---|
| BIRTH NO. 65 1294 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Richard Robinson | | | | 2. DATE AND HOUR OF DEATH 2/2/65 11:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1609 N. Smallwood St | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1503 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1609 N. Smallwood St. | |
| 5. SEX M. | 6. RACE C. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W. | 8. DATE OF BIRTH 10/10/99 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshore man | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Major Robinson | | | 14. MOTHER'S MAIDEN NAME Elnora | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Annie Ruffin 1609 N. Smallwood St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Myocardial infarct | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | (A) DUE TO Hypertensive atherosclerotic heart disease (B) DUE TO Anterovascular (C) Myocardial infarct | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gout | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2 July 1960 to 2 Feb 1964 , that (I) (we) last saw the deceased alive on 29 Jan 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. R. Davidson | | | | 23B. DATE SIGNED 2/4/65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles R. Davidson | | | | 23D. ADDRESS 2034 W North Ave Baltimore Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St. | | | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)(Lucy)
LUCI WORSLEY

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965

5:37 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2500 Keyworth Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

July 1870

9. AGE (In years
last birthday)

94

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Fletcher Lee

14. MOTHER'S MAIDEN NAME

Rebecca

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

2500 Keyworth Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH422.1 + 170X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Carcinoma of the breast

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-2-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-7-65

23C. NAME of CEMETERY or CREMATORY

Rural Cem.

23D. LOCATION

(City, town, or county)

Tarboro

(State)

N.C.

24A. DATE REC'D BY HEALTH DEPT.

FEB 4 1965

24B. NAME OF REGISTRAR

Robert E. Fisher M.D.

24C. FUNERAL DIRECTOR

Sullivan Funeral Home - N. Arlington Ave

ADDRESS

WALTER FORD

DEPARTMENT OF JUSTICE

NO 2

LS: 42-64-81

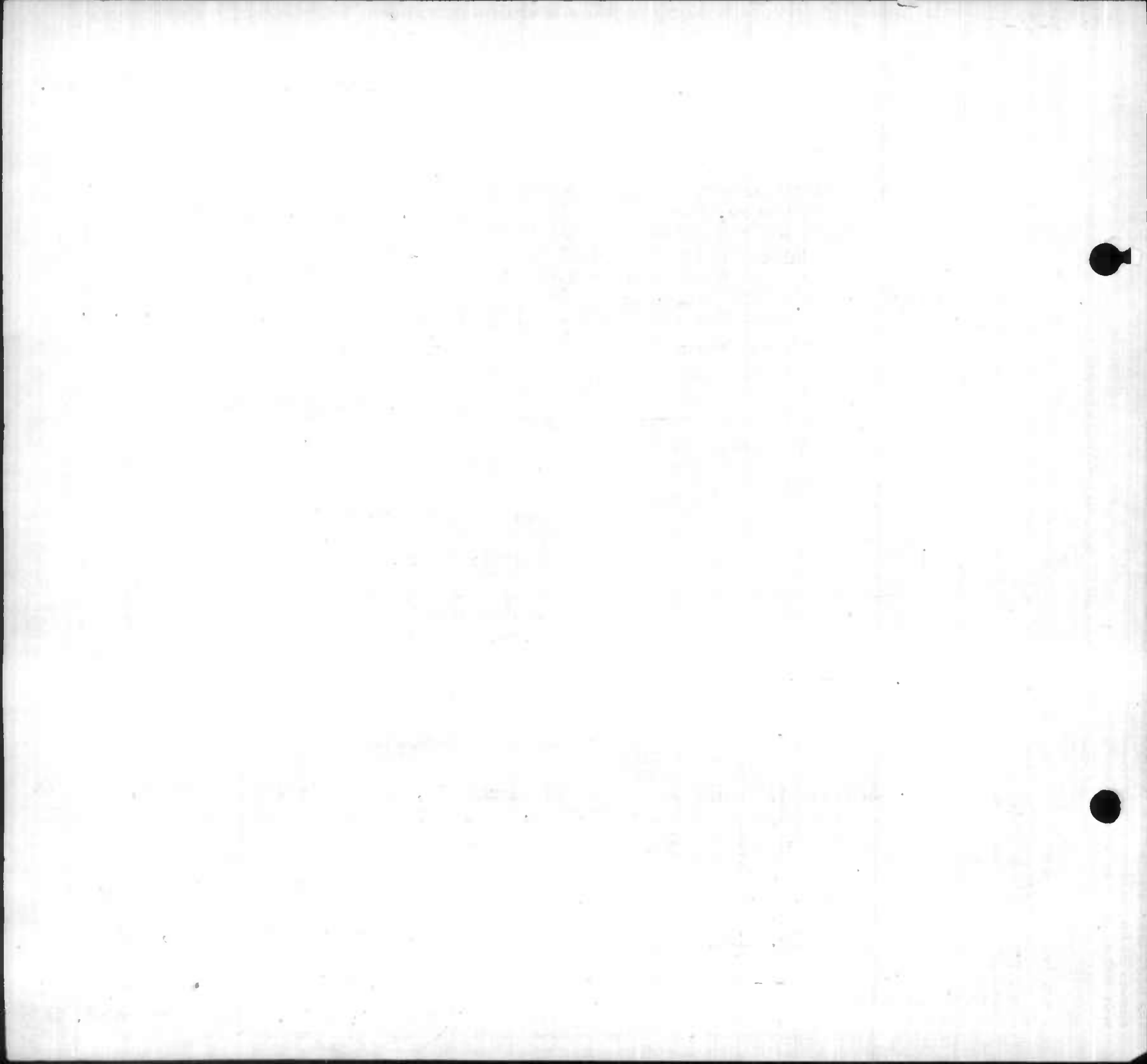
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1296

| | | | |
|--|------------------|---|------------------------------|
| BIRTH NO. 65 1296 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) Louis P. Wagner | | 2. DATE AND HOUR OF DEATH January 31, 1965 10:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1113 S. Curley Street 21224 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) Married | 8. DATE OF BIRTH 12-28-01 |
| 9. AGE (In years lost birthday) 63 | | 10. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Humble Oil Co. | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George Wagner | | 14. MOTHER'S MAIDEN NAME Sally Bayer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT RECORDS: BCH: 4940 Eastern Avenue 21224 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 340.0 I ? Septic Shock (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 Day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Gastrectomy Wound Adhesive (B) DUE TO Gram Negative Pneumonia (C) Gastric Ulcer | | 1 Week | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 1-20-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19, 1965 to January 31, 1965, that (I) (we) last saw the deceased alive on January 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Richard Lane | | 23B. DATE SIGNED January 31, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Richard Lane | | 23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-5-1965 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Rosary | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Farker, M.D. | |
| 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. | | ADDRESS 1901 Eastern Ave. | |



BIRTH NO. 64-34208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

DURANTE M. HINES

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965 10:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2623 N. Hilton St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2623 N. Hilton St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec 13, 1964

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Albert Hines

14. MOTHER'S MAIDEN NAME

Shirley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Shirley Hines 2623 N. Hilton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Respiratory infection
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-3-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 4 1965

WALTER B. POINTE

REPRODUCTION

106A

THE HISTORY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|----------------------|---|--|--|--|--|--|--|--|
| 65 1298 | | | | | 65 1298 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED (Type or Print) PRESTON ROBERT HALL | | | | | 2. DATE AND HOUR OF DEATH FEBRUARY 1, 1965 7:30 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | | | A. STATE MARYLAND B. COUNTY Balto | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 908 DULANEY VALLEY COURT | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1/1/1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN | | | 10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE COUNTY POLICE DEPT | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME TAYLOR HALL | | | | | 14. MOTHER'S MAIDEN NAME MINNIE ELIZABETH HEFFLIN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN no | | | 16. SOCIAL SECURITY NO. 215 05 6793 | | 17. INFORMANT Mrs Mary M. Hall | | | | ADDRESS 908 Dulane Valley Court |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarct ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary emboli, bilateral Coronary heart disease | | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 16 19 65 to FEBRUARY 1st 19 65 , that (I) (we) last saw the deceased alive on FEBRUARY 1st 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE William R. Linton, Jr. | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 1/2/65 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM R. LINTON, JR. | | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/5/65 | | 24C. NAME OF CEMETERY OR CREMATORY FORK M.E. CHURCH | | 24D. LOCATION (City, town, or county) FORK MARYLAND | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fairley | | 25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. | | | ADDRESS BALTIMORE MARYLAND 21213 | |

PLATE 1

42-72-13 AM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1299

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

David Wilson

2. DATE AND HOUR OF DEATH

2-2-65

12:35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE CORRECTED 2-8-65

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

6104 O'Donnell Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-15-1899

9. AGE (In years
last birthday)

65

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Caretaker

10B. KIND OF BUSINESS OR INDUSTRY

Cemetery

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Wilson

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

217 03 7460

17. INFORMANT

Mrs Dessie O. Wilson 6104 O'Donnell

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

332 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

2 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Bilateral Middle Cerebral Artery
DUE TO Thrombosis

3 weeks

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-28 19 65 to 2-2- 19 65
that (I) (we) lost saw the deceased alive on 2-2- 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Stoff.
Phys. ☒

23B. DATE SIGNED

2-2-65

23C. PHYSICIAN'S
NAME (Type)

Dr. M. Schuster

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/5/65

24C. NAME OF CEMETERY or CREMATORY

St/ Matthews Cemetery

24D. LOCATION

Baltimore Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 4 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

HENRY SANDER & SONS INC.

ADDRESS

BALTIMORE MARYLAND 21213

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from City Hospitals

2-8-65

M.H.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM NEEDER (WILLIAM DAVID NEEDER February 3, 1965

1:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Armco Steel Corporation-Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5 N. Port St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

January 16, 1904 61

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stocker Armco Steel Corporation

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Conrad Needer

14. MOTHER'S MAIDEN NAME

Catherine Rohlfing

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212 05 7569

17. INFORMANT

5 North Port Street
Mrs Marguerite Needer

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Blunt force injury to lower abdomen
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Steel Corp.

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3501 E. Biddle St., Armco Steel Corp.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
2 3 65 1:10p

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently struck by heavy load

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/6/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie Maryland

24A. DATE REC'D BY HEALTH DEPT.

FEB 4 1965

24B. NAME OF REGISTRAR

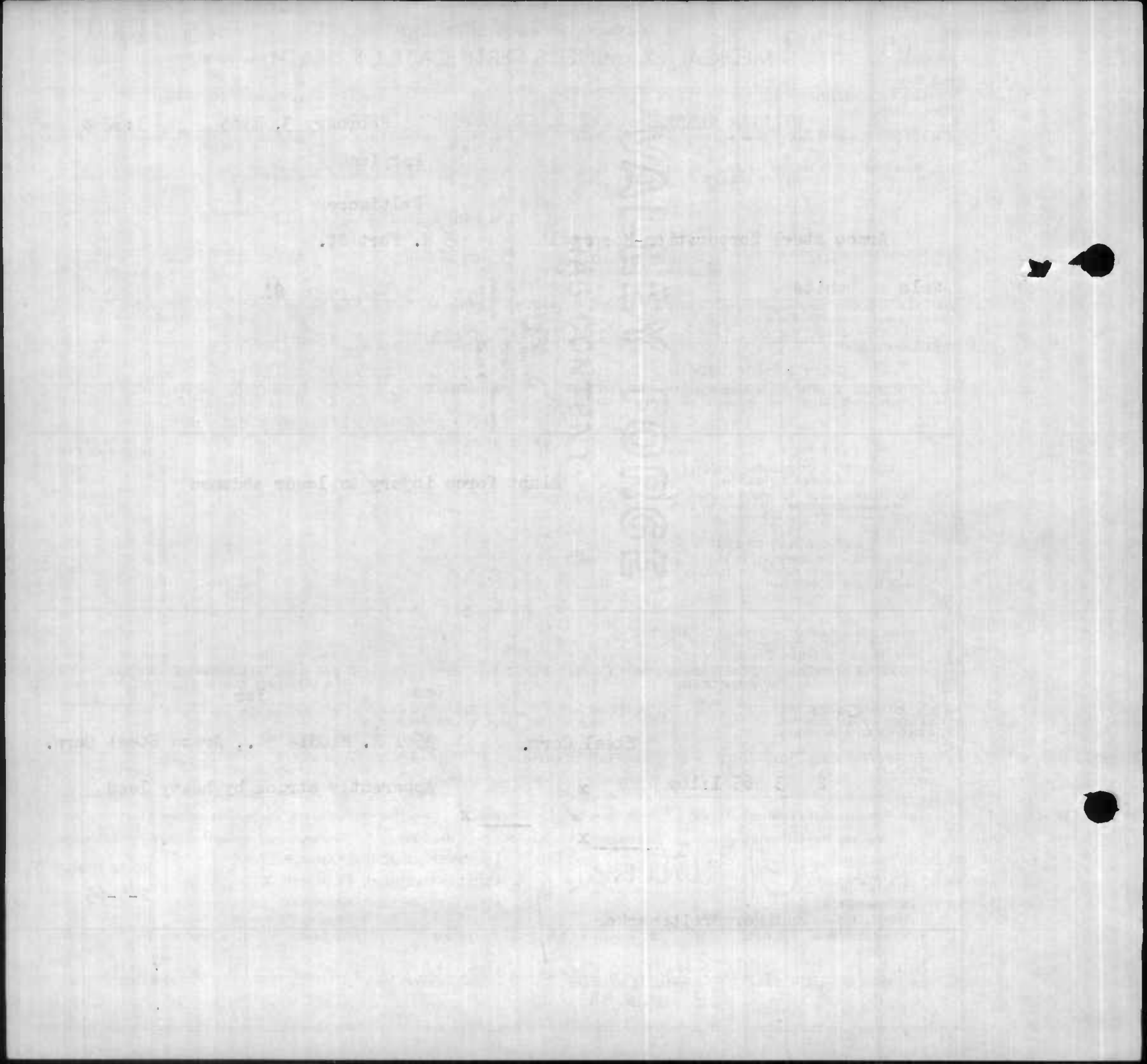
Robert E. Tarkenton

24C. FUNERAL DIRECTOR

HENRY SANDER & SONS INC.

BALTIMORE, MARYLAND 21213

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 65 1301 | | CERTIFICATE OF DEATH | | Registered No. 65 1301 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Mrs. Catherine O. Kinnear | | | Feb 2 1965 11:55 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Gen. Hospital | | | A. STATE MD B. COUNTY 905 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 1337 Gorsuch Ave | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9-2-1898 | 9. AGE (In years last birthday) 66 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MF | | 10B. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) MD | |
| 13. FATHER'S NAME Henry Yost (Dec?) | | | 14. MOTHER'S MAIDEN NAME Blanche Bond (Dec?) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS Wm H. Kinnear 5816 Northwood Dr | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I | | | CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO (B) Arteriosclerotic cardiovascular disease DUE TO (C) disease | | |
| INTERVAL BETWEEN ONSET AND DEATH 4 hours | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 22 19 65 to Feb 22 19 65 , that (I) (we) lost saw the deceased alive on Feb 2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Youngsik Moon | | | | 23B. DATE SIGNED Feb 2 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Youngsik Moon | | | | 23D. ADDRESS M.D. Maryland Gen. Hospital, Baltimore, MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/5/65 | | 24C. NAME OF CEMETERY or CREMATORY WOODLAWN | |
| 24D. LOCATION (City, town, or county) WOODLAWN BALTO. CO MD | | 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co 4905 York Rd. | | | |

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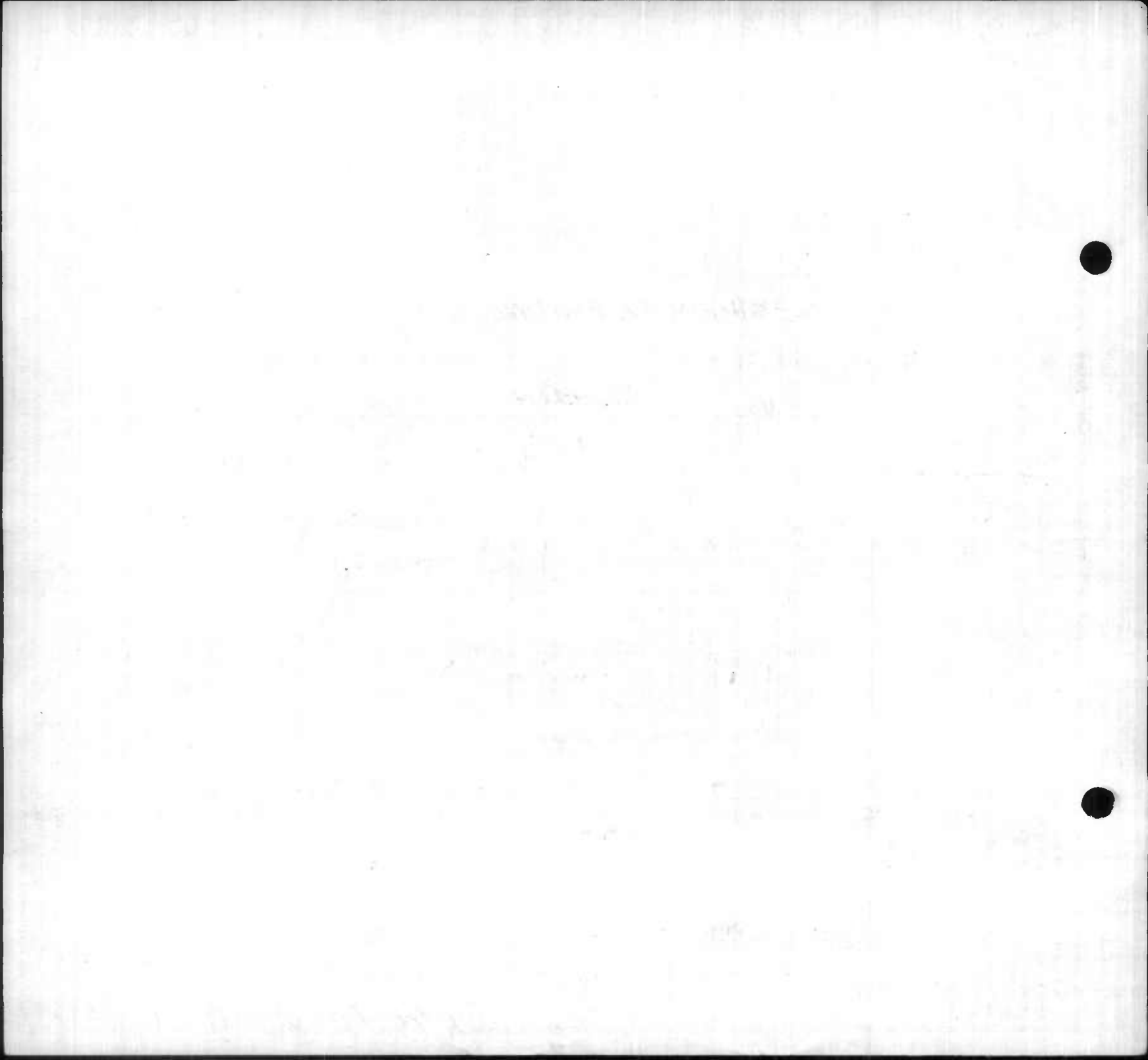
1000 1000
1000 1000



1000 1000
1000 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

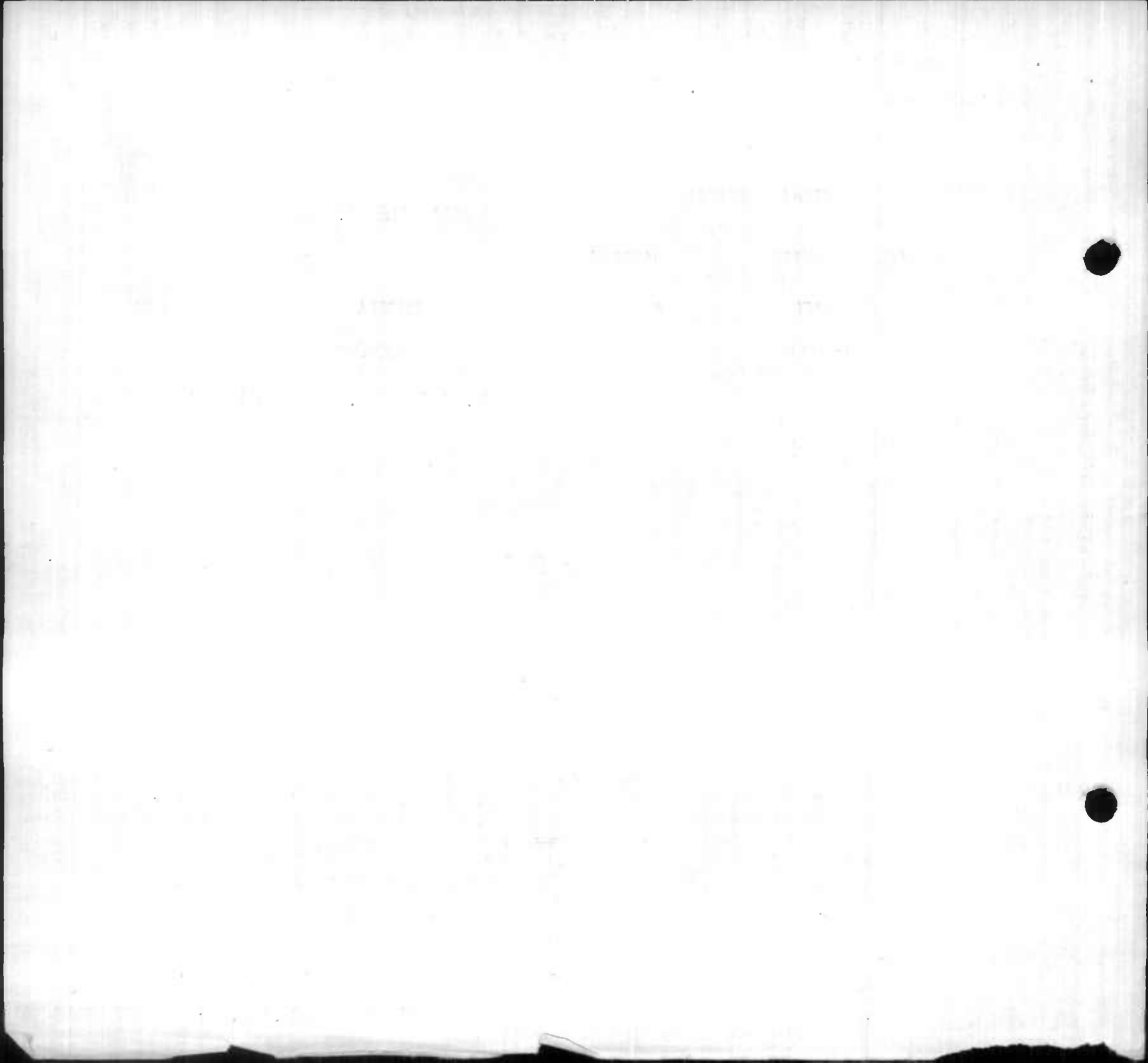
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

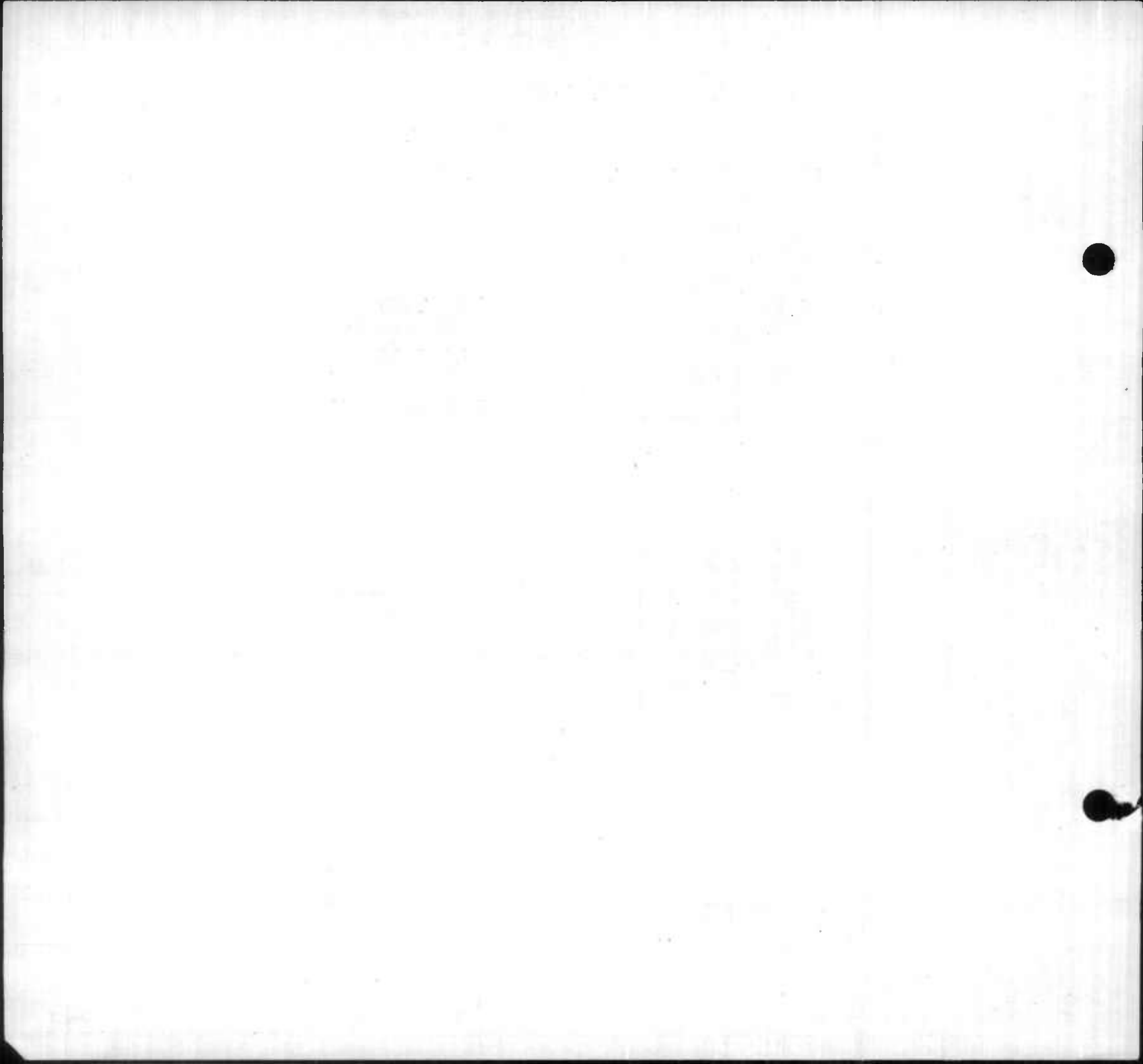
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1303 | | | | | | | |
| BIRTH NO. 65 1303 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) MINNIE S. COHEN | | | 2. DATE AND HOUR OF DEATH FEBRUARY 2, 1965 7:45 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4002 GLEN AVENUE | | | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 70 | | 9. AGE (In years last birthday) 70 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME UNKNOWN | | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MR. ABRAHAM B. COHEN 4002 GLEN AVENUE | | | | | |
| 18. 572.1 T-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Septicemia DUE TO (B) Peritonitis DUE TO (C) Perforation of Sigmoid Diverticulum | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours 36 hours 48 hours | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Diabetes Mellitus 10 years | | | | | | | |
| 19A. DATE OF OPERATION 1/31/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Sigmoid Diverticulum | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from 1/31 19 65 to 2/2 19 65 , that the (we) last saw the deceased alive on 2/2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (not) view the body after death. | | | | | | | | | | | | |
| 23A. SIGNATURE Stephen L. Weitz | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/2/65 | | |
| 23C. PHYSICIAN'S NAME (Type) Stephen L. Weitz | | | | | | | | 23D. ADDRESS M.D. Sinai Hospital of Baltimore | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | | | 25B. NAME OF REGISTRAR Gleub E. Farley, M.A. | | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

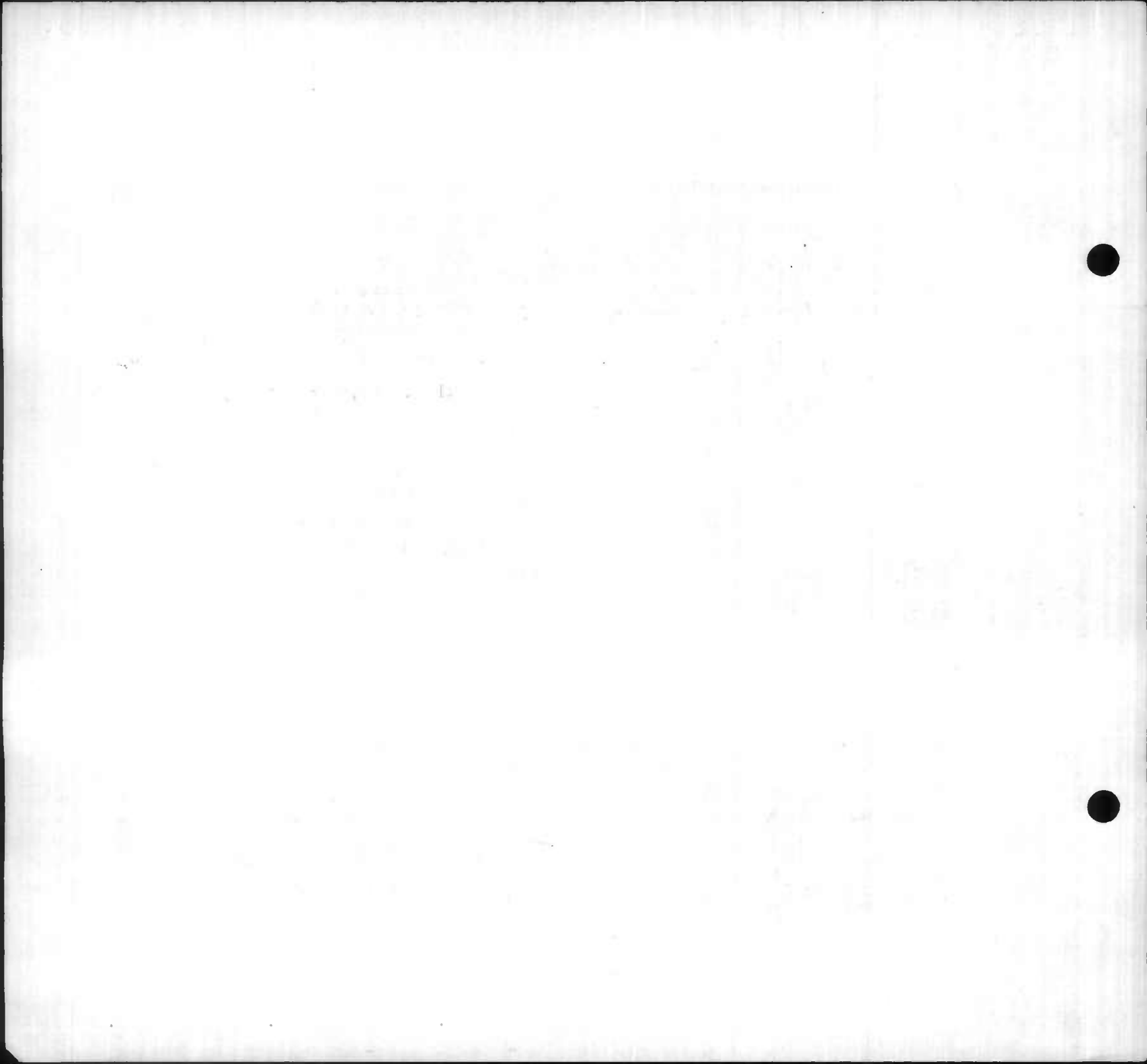
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|-----------------------------|--|
| BIRTH NO. 65 1304 | | | | | | REGISTERED NO. 65 1304 | | | | | |
| M.E. CASE NO. | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| ANNA CATHERINE LIESKE | | | | | | 2 3 65 10PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | A. STATE B. COUNTY | | | | | |
| ST AGNES HOSPITAL | | | | | | MARYLAND | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | | | RISING SUN | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | | | 57-00 | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. UNDER 1 Yr. Months Days | |
| FEMALE | | WHITE | | WIDOWED | | 10 1 83 | | 81 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| RETIRED HSWFE | | | | | | | | MARYLAND | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| | | | | | | FLORENCE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | | | | | ST AGNES HOSP RECORDS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH | | | | | |
| | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| | | | | | | 1-2 days | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) Acute Myocardial Infarction | | | | | |
| | | | | | | (B) Obstructive jaundice | | | | | |
| | | | | | | (C) CVA | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | | | Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1 29 19 65 to 2 3 1965, that (I) (we) last saw the deceased alive on 2 3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | |
| DR FRANK M DETORE | | | | | | | | | | 2/4/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | | | |
| | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | | | |
| BURIAL | | 2/7/65 | | BROOKVIEW CEM. | | RISING SUN | | MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | | |
| FEB 4 1965 | | Robert E. Farley, M.D. | | Ralph M. Reed, Rising Sun, Md. | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

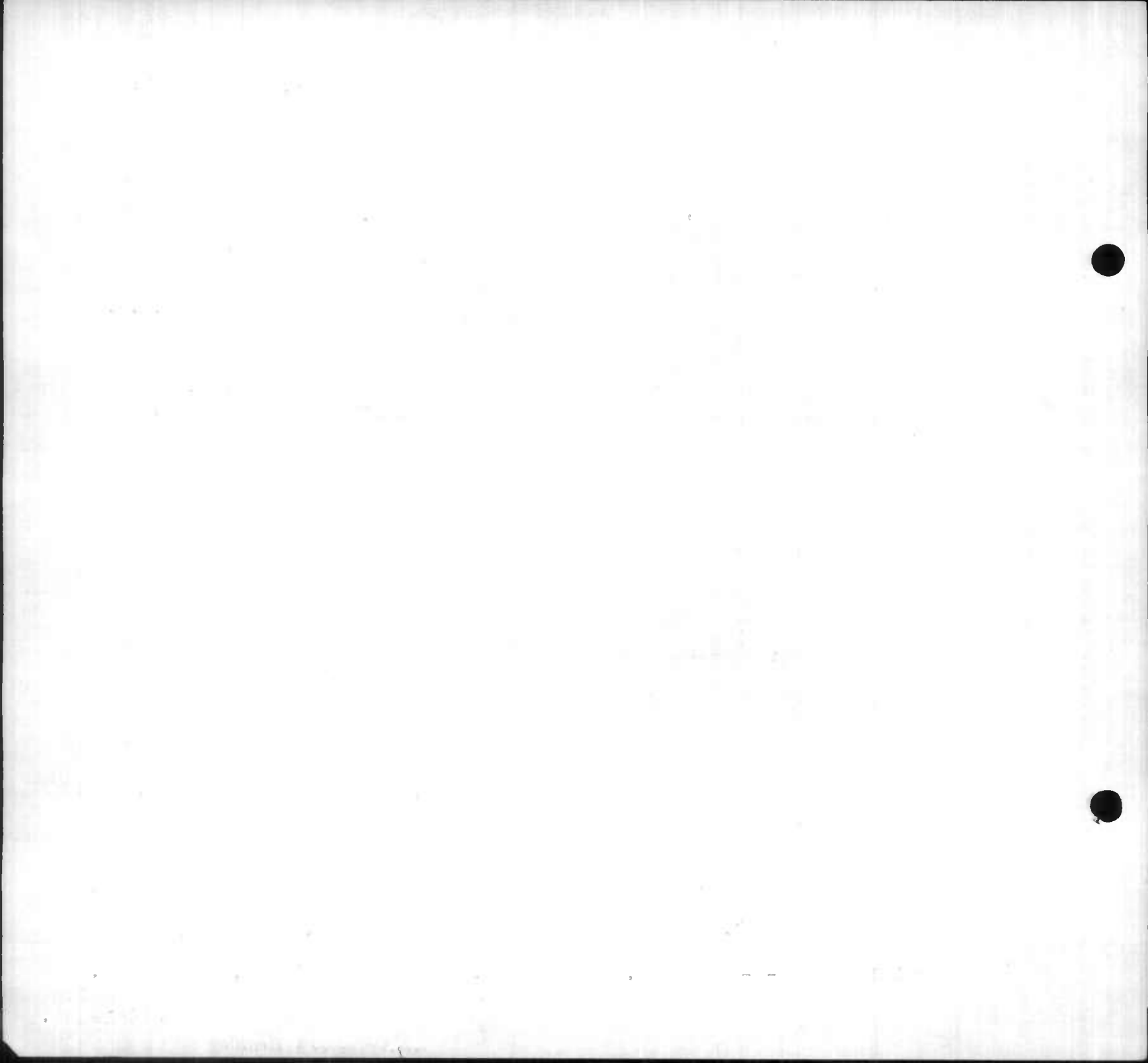
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|----------------------|--|---|---|---|
| BIRTH NO. 65 1305 | | CERTIFICATE OF DEATH | | Registered No. 65 1305 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Beatrice R. Kerr | | 2. DATE AND HOUR OF DEATH 2-1-65 3¹⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson D. STREET ADDRESS (If rural, give location) 9 West Road | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9-26-91 | 9. AGE (In years last birthday) 73 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Underwriter |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Underwriter | | 10B. KIND OF BUSINESS OR INDUSTRY Maryland Casualty Company | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Henry D. Rullman | | | 14. MOTHER'S MAIDEN NAME Emma C. Willis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 549-32-6530 | 17. INFORMANT Faith L. Kerr ADDRESS 9 West Road, Towson 21204 | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION (s). | | CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Disease DUE TO (B) Cerebral Vascular Accident DUE TO 2° to Cerebral Thrombosis (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 1-30-1965 to 2-1-1965 , that it (we) last saw the deceased alive on 2-1-1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lawrence J. Luberman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | 24B. DATE 2-5-65 | | 24C. NAME OF CEMETERY or CREMATORY Green Mount | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wm. Cook-Towson, Inc., 1050 York Rd. TOWSON 4 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-----------|--|---|--|--|
| BIRTH NO. | | 65 1306 | | 65 1306 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Mary White | | | January 31, 1965 8:05p M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Provident Hospital 1514 Division Street Baltimore 17, Maryland | | | Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1016 N. Calhoun Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days Hours Min. |
| Female | Negro | widowed | 2 | 85 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | None | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| ? | | | ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | 1209 N. Calhoun Street Baltimore, Maryland | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) Acute Pulmonary Edema DUE TO (B) Arteriosclerotic CardioVascular Disease DUE TO (C) Generalized Arterio sclerosis | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 29, 1965 to January 31, 1965, that (I) (we) last saw the deceased alive on January 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Hollis Seunarine, M.D. | | | | January 31, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| Hollis Seunarine | | | 1514 Division St.-Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) | (State) |
| Burial | 2-4-65 | Mt. Auburn Cem. | | Baltimore, | Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 4 1965 | | Robert E. Taylor, M.D. | | 578W Biddle St. (Mrs) Frances A. Homley | |

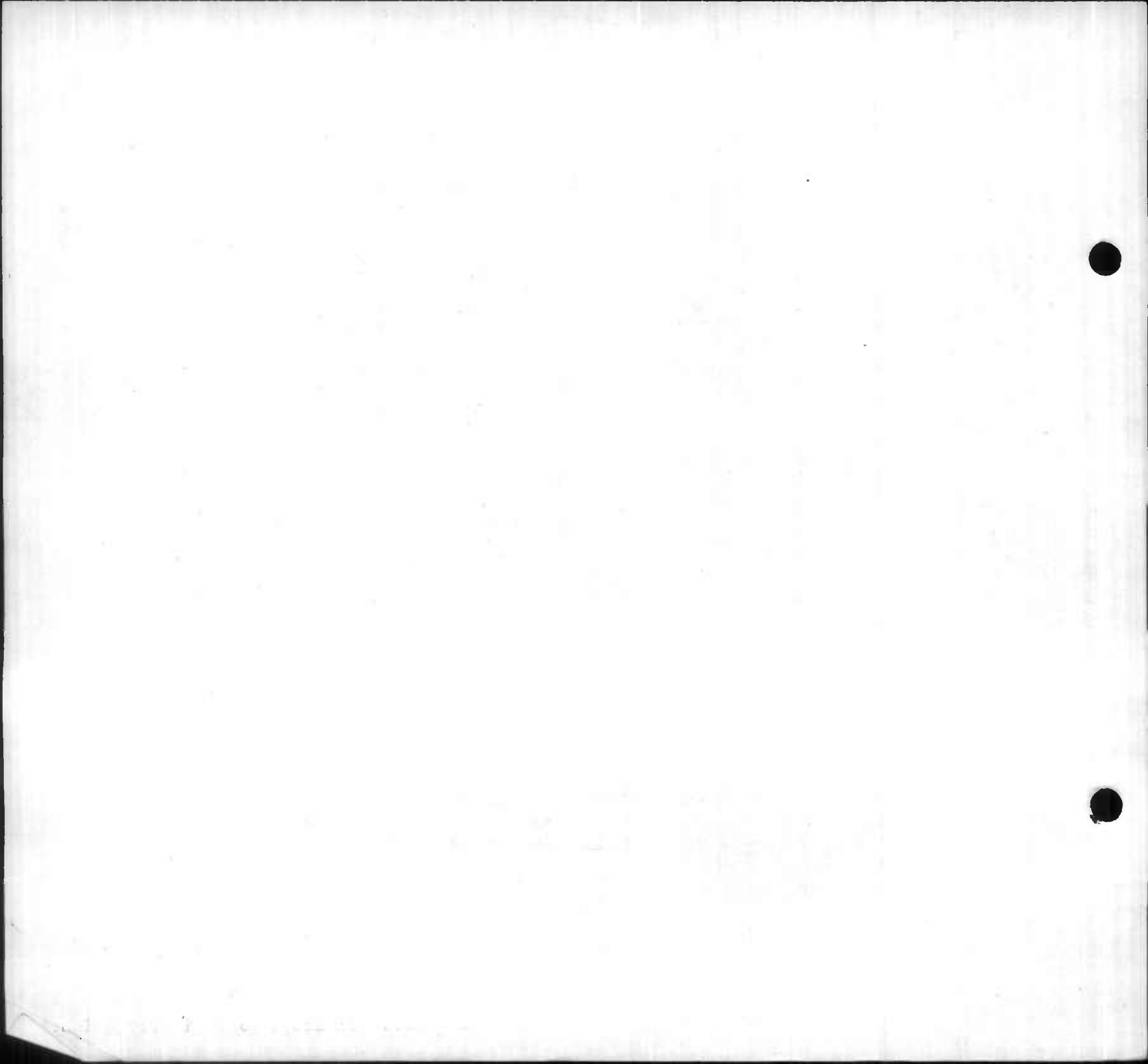


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-6001

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|--|--|--|---|---|------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1307 | | | | |
| BIRTH NO. 65 1307 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) JENNIE LUCILLE R. MOORE | | | | | 2. DATE AND HOUR OF DEATH 1-31-65 3:30 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MARYLAND B. COUNTY BALTO | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP. OF MD. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #7 5300 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 2304 BIRCH DR. | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 10-14-80 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) CHAMPAINE, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Heber Roberts | | | | 14. MOTHER'S MAIDEN NAME MINNESOTA McALLISTER | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Russell R. Johnson | | | | | |
| 18. 420.1 I | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH N.J. | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Acute Myocardial Infarction | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (B) Arterio Sclerotic Cardiovascular | | | | | | | |
| ANTECEDENT CAUSES | | (C) Disease w/ Congestive Heart Failure | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-30-1965 to 1-31-1965 , that (I) (we) last saw the deceased alive on 1-31-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Jesus G. Sanhau | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-31-65 | | |
| 23C. PHYSICIAN'S NAME (Type) LUTHERAN HOSP. OF MD | | | | 23D. ADDRESS ELLSWORTH ARMACOST 4600 LIBERTY HEIGHTS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 2/3/65 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Jankowski | | 25C. FUNERAL DIRECTOR Ellsworth Armacost | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Baltimore City Health Department | |
|--|---------|--|---|--|--|
| BIRTH NO. | | 65 1308 | | Registered No. 65 1308 | |
| M.E. CASE NO. | | | | 28-41 | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Arthur R. Meredith | | | February 3, 1965 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE | | |
| | | | B. COUNTY | | |
| Anderson Nursing Home | | | Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 3604 Mohawk Avenue | | |
| | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. AGE (In years last birthday) |
| Male | White | Single | Feb. 26, 1875 | 89 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| P.R.R. Chief of Reestate | | | Harrisburg, Pa. | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Charles W. Meredith | | | Anna Sprigman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT |
| No | | | 716-16-7926 | | F. Meredith Wood 106 W. University Pkwy. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) Cerebral Vascular accident | | Immed |
| | | | (B) Cardio-vascular disease | | 10 yrs |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to Feb 3 1965, that (I) (we) last saw the deceased alive on Feb 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Homer U. Todd M.D. | | | | 2/4/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Homer U. Todd M.D. | | | | 2108 St Paul St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2-5-65 | | East Harrisburg Cemetery | |
| | | | | Harrisburg, Pennsylvania | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR'S ADDRESS | |
| FEB 4 1965 | | Robert E. Stanley M.D. | | 644 North Anna cost - 4400 Liberty Hgts Ave | |

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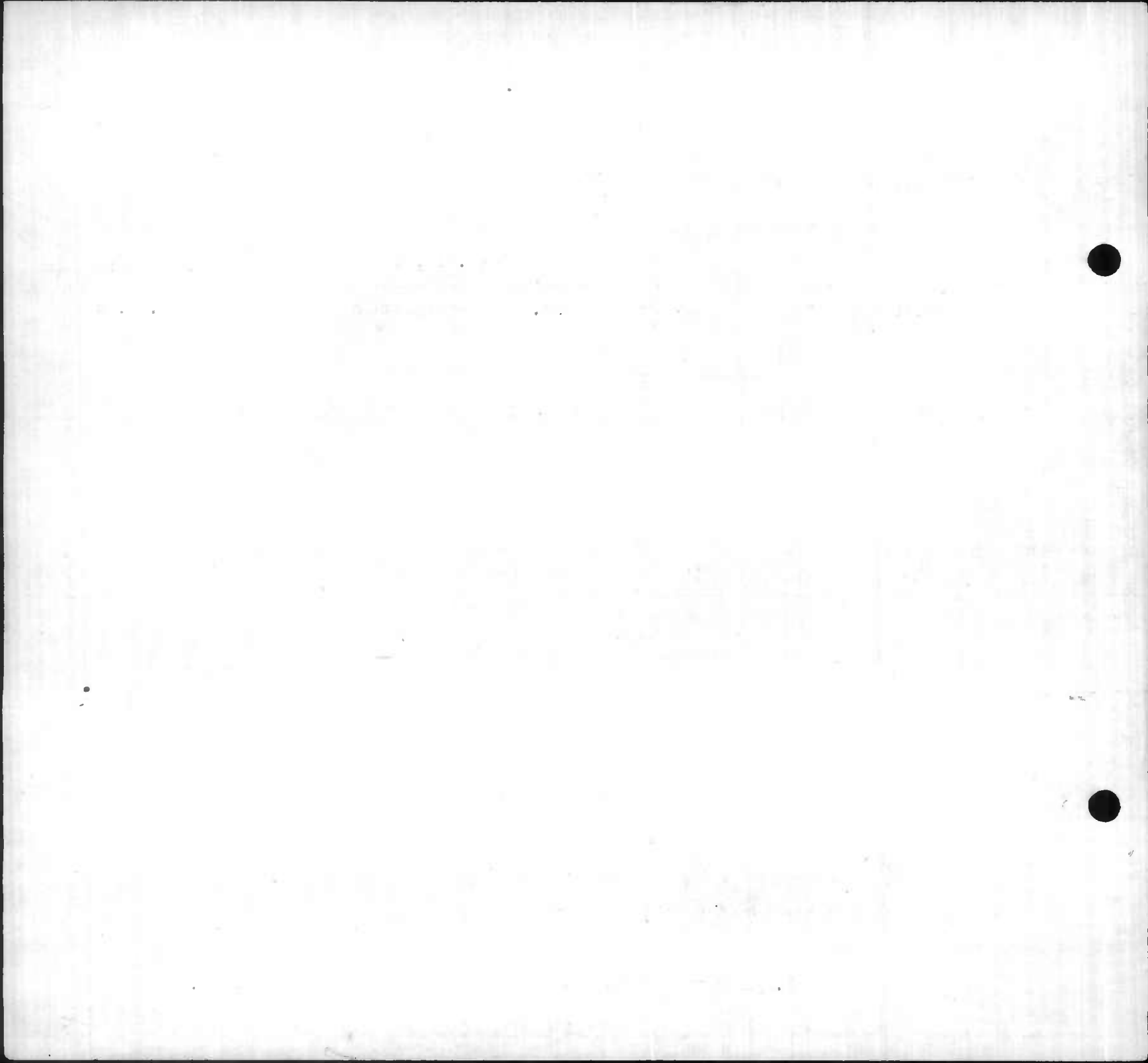
D-524/1

for approval by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1309 | |
|--|---------------------|--|--|--|---|
| BIRTH NO. 65 1309 | | | | CERTIFICATE OF DEATH X | |
| 1. NAME OF DECEASED (Type or Print) Daukleberger, Robert R. | | | 2. DATE AND HOUR OF DEATH February 3 1965 7:27 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY Wyomissing | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND Hosp | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Wyomissing | | |
| | | | D. STREET ADDRESS (If rural, give location) 805 Wayne Avenue | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 10, 1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President | | 10B. KIND OF BUSINESS OR INDUSTRY Savings and Loan Wyomissing Assoc. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME ? | | | 12. CITIZEN OF WHAT COUNTRY? U. S. a | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 159-01-1113 | | |
| 17. INFORMANT University Hospital Records | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive Hemorrhage Ruptured Abdominal Aortic Aneurysm | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | |
| 19A. DATE OF OPERATION Feb 3 65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aneurysm | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 3 1965 to Feb 3 1965 , that (I) (we) last saw the deceased alive on Feb 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph S. McLaughlin M.O. | | | | 23B. DATE SIGNED Feb 3, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ARLIE R. MANSBERGER JR Joseph S. McLaughlin M.O. | | | | 23D. ADDRESS University Hospital, Balto. Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 2/4/1965 | | 24C. NAME OF CEMETERY OR CEMATORY Laurel Dale Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Laurel Dale, Pa. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR Wm J. Tichner & Sons | |
| | | | | ADDRESS Balt 17 Md. | |

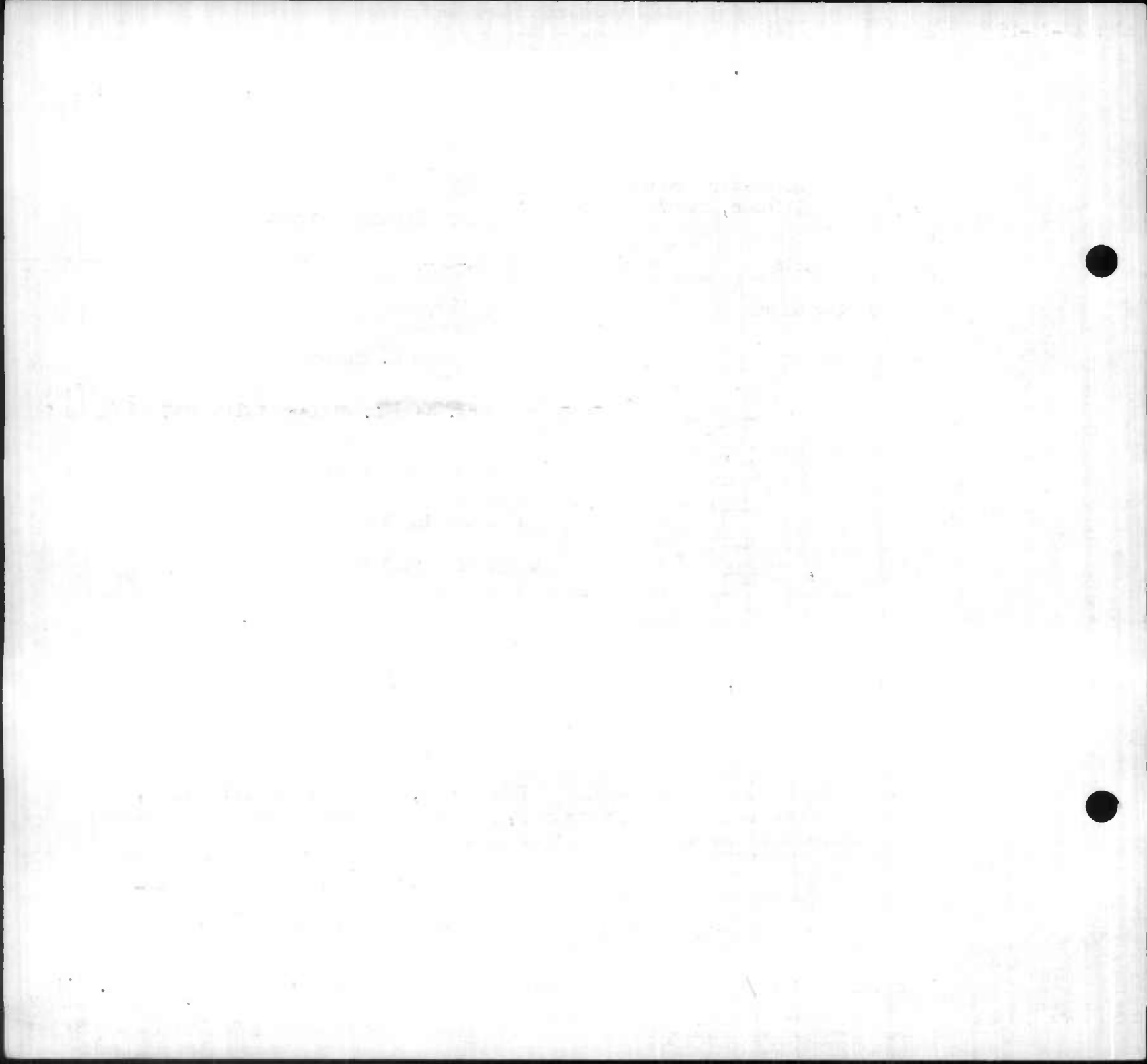


cdg: 42-75-15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

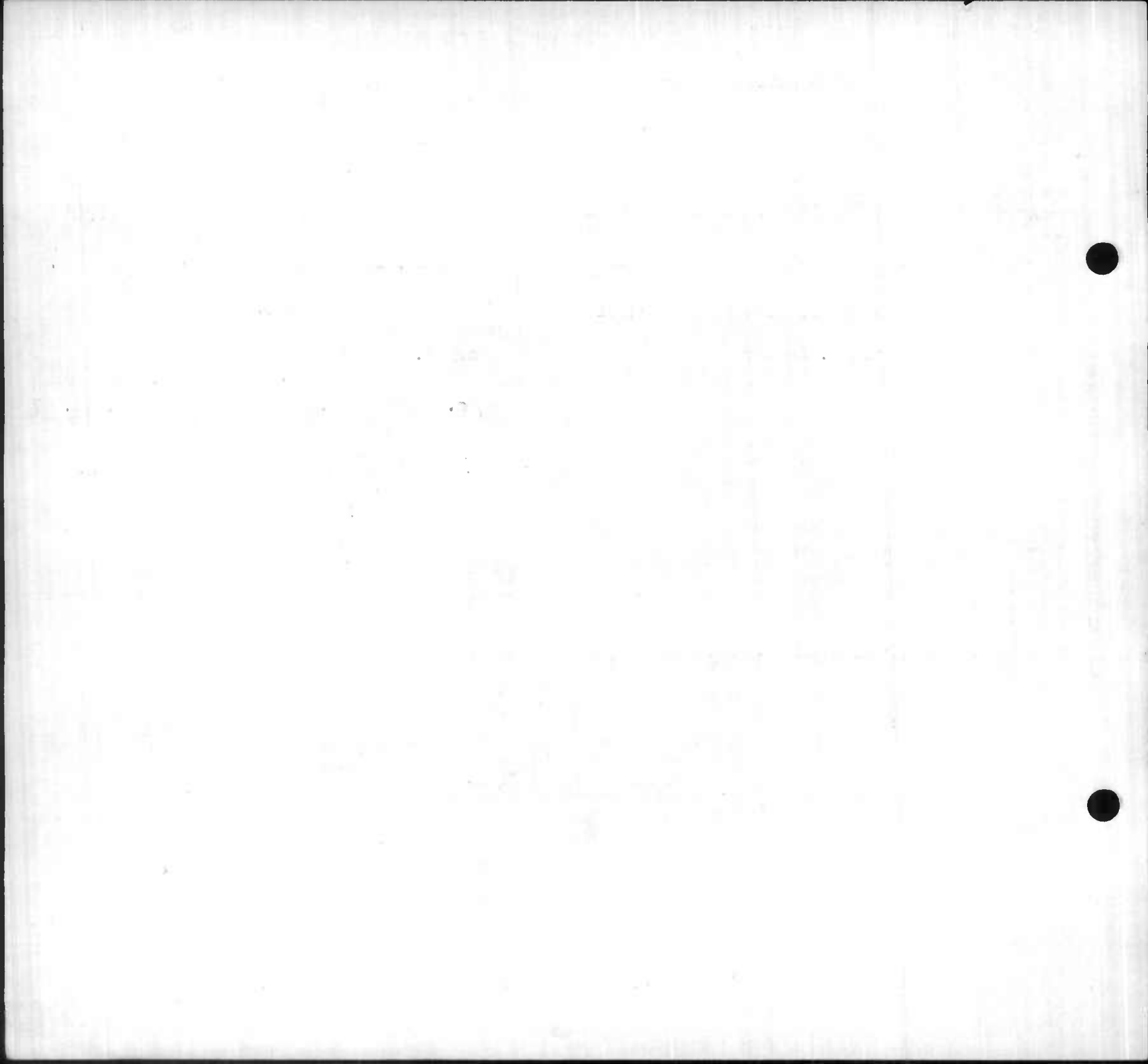
| BIRTH NO. 65 1310 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1310 | |
|--|---------|--|------------------|--|------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | C. Samuel Miller | | February 3, 1965 6:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | Maryland | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 3-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 107 Albemarle Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? | | | | |
| Male | White | Married | 4-20-96 | 68 | USA | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Port Security Guard | | | | | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Herman Miller | | | | Laura C. Howard | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No None | | | | 220-03-0810 | | 107 Albermarle Street Mrs. Mary L. Miller Baltimore, Maryland 2 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | Emphysema | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 1, 1965 to February 3, 1965, that (I) (we) last saw the deceased alive on February 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | |
| | | | | | | | | 1-3-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Marvin Schuster | | | | M.D. 4940 Eastern Avenue 21224 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 2/6 /65 | | Schwartz Cemetery | | Balto., | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | |
| FEB 4 1965 | | Robert E. Farber, M.D. | | Wm. J. Flickner & Sons North Pa. Avenue | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

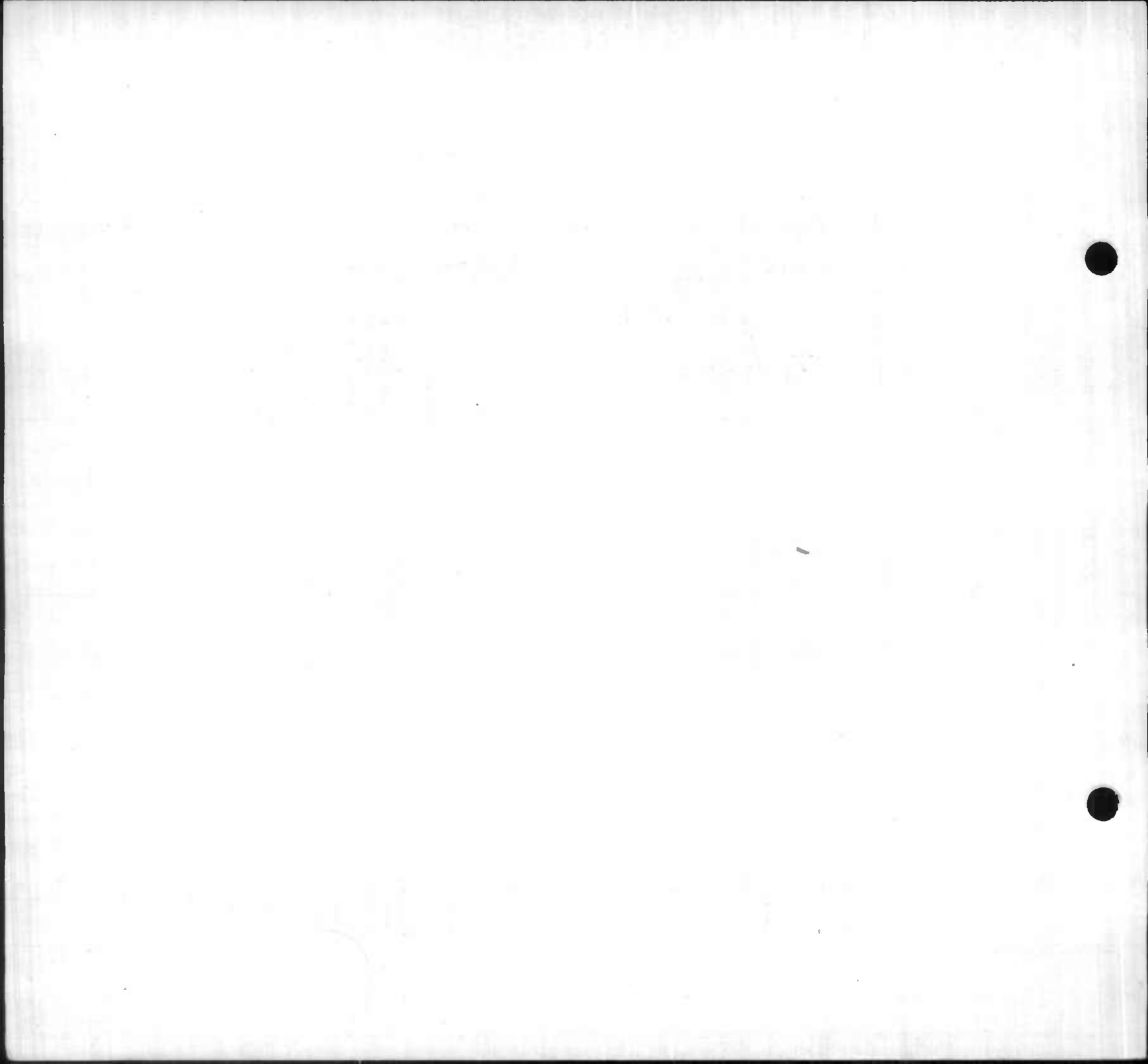
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1311 | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. 65 1311 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Emma Amelia Snyder | | | | February 4, 1965 6:15 a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3307 Piedmont Avenue Baltimore, Maryland 21216 | | | | A. STATE Maryland B. COUNTY 15-37 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 3307 Piedmont Avenue 21216 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH March 14, 1870 | | 9. AGE (In years last birthday) 94 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Schoolteacher | | | 10B. KIND OF BUSINESS OR INDUSTRY School | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME Benjamin B. Snyder | | |
| 14. MOTHER'S MAIDEN NAME Mary A. Ballard | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. Florence M. Ballard ADDRESS 3021 Fendall Road Baltimore, Md. 7 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO Arteriosclerosis, general | | | | INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 28 1964 to Feb. 4 1965 , that (I) (we) last saw the deceased alive on Feb. 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Abraham B. Hurwitz | | | | 23B. DATE SIGNED Feb. 4, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ | | | | 23D. ADDRESS 3403 GARRISON BLVD. BALTIMORE MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/6/1965 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 4 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Jackson - 2000 North Ave. Baltimore, Md. 17 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

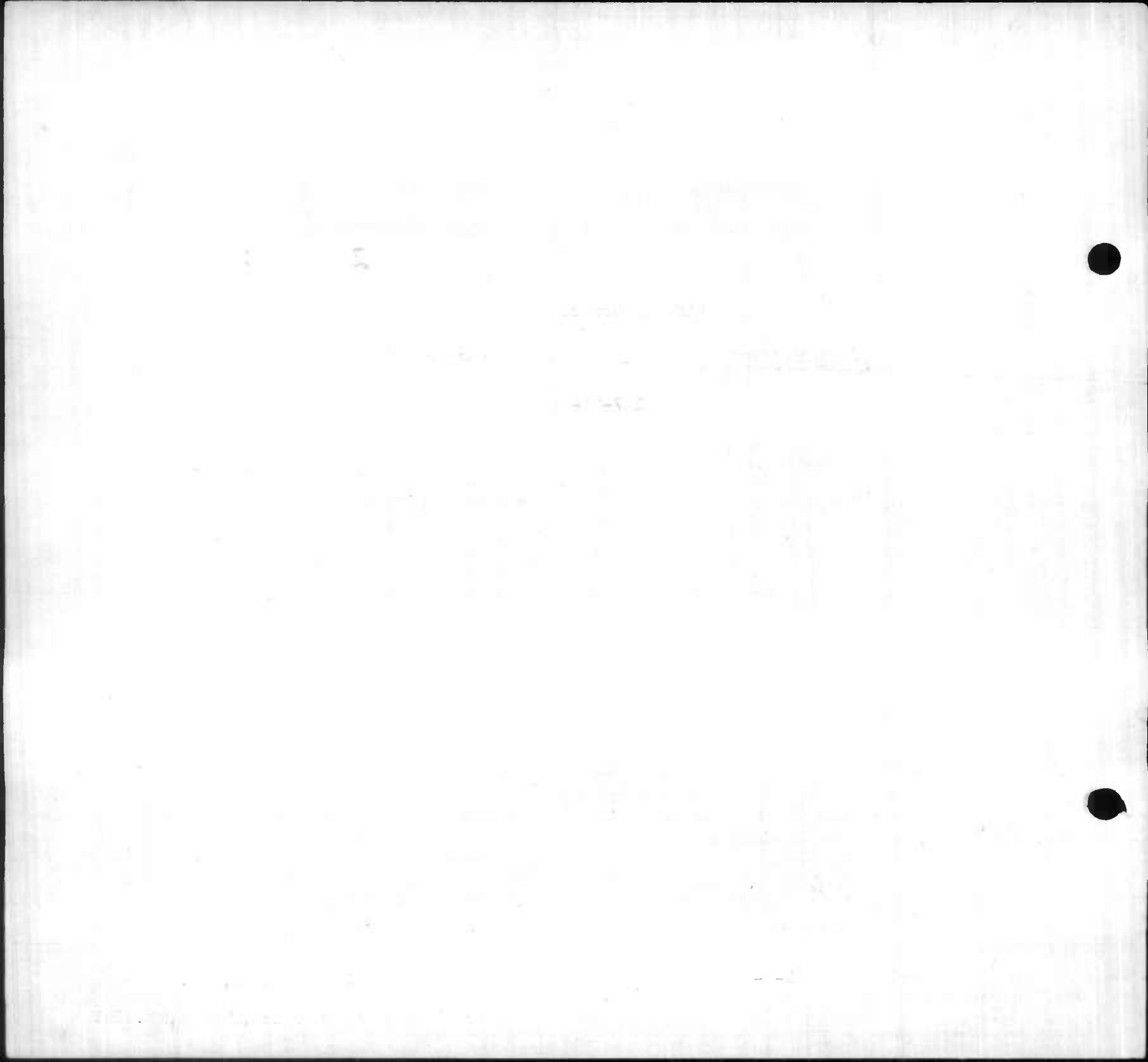
| | | | |
|--|--|---|--|
| 64-24125 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| BIRTH NO. 65 1312 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | Registered No. 65 1312 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| Stephanie F. Lehman | | Feb. 2, 1965 4:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| South Baltimore General Hosp. | | Maryland. AA. 52-00 | |
| 5. SEX F. 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | Baltimore #212 26 | |
| 10B. KIND OF BUSINESS OR INDUSTRY child. | | D. STREET ADDRESS (If rural, give location) | |
| 13. FATHER'S NAME Ernest Lehman | | 213 Sycamore Road. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 8. DATE OF BIRTH 11-29-1964 2 months | |
| 16. SOCIAL SECURITY NO. | | 9. AGE (In years last birthday) | |
| | | 11. BIRTHPLACE (State of foreign country) Maryland. | |
| | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| | | 14. MOTHER'S MAIDEN NAME Mary L. Jones. | |
| | | 17. INFORMANT Ernest Lehman - Above | |
| 18. 491 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) Septicemia DUE TO | |
| | | (B) Acute Bronchopneumonia DUE TO | |
| | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs. | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 20A. AUTOPSY? (Yes or No) YES. | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 2-2 19 65 to 2-2 19 65, that (we) lost saw the deceased alive on 2-2 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Edgar V. McGinley | | 23B. DATE SIGNED 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) Edgar V. McGinley | | 23D. ADDRESS South Baltimore General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Glen Haven | | 24D. LOCATION (City, town, or county) (State) Glen Burnie Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| | | 25C. FUNERAL DIRECTOR Robert A. Baranco - Avenue 4th and | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

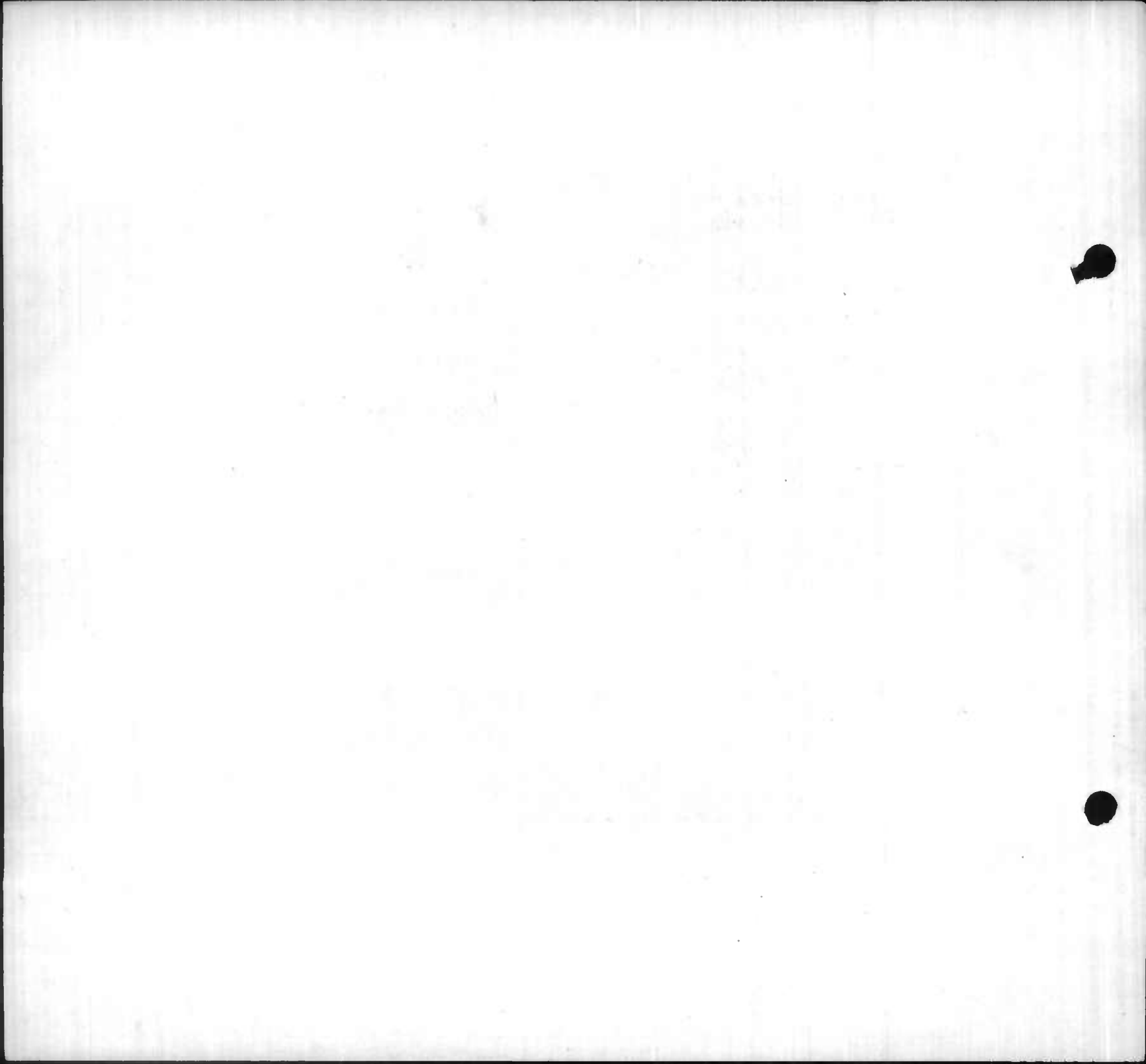
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1313 | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 65 1313 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Edwin Carl Hermann</i> </div> <div> 2. DATE AND HOUR OF DEATH <i>2-2-65 8:15 am</i> A M. </div> </div> | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION <i>The Hospital for the Women of Maryland</i> </div> <div style="flex: 1;"> (If not in hospital or institution, give street address or location) </div> </div> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i> | | | | | | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i> | | | | | 8. DATE OF BIRTH <i>2-29-92</i> 9. AGE (In years last birthday) <i>73</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Semi-Retired Insurance agent</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, md.</i> | | |
| 10A. KIND OF BUSINESS OR INDUSTRY <i>life insurance</i> | | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>John Hermann</i> | | | 14. MOTHER'S MAIDEN NAME <i>Minnie Hoenes</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | | 16. SOCIAL SECURITY NO. <i>217-26-0011</i> | | 17. INFORMANT <i>chart.</i> | | | ADDRESS | |
| 18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) DUE TO <i>Myocardial infarction arteriosclerosis</i> (B) DUE TO (C) </div> </div> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-18</i> 19 <i>65</i> to <i>2-2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>2-2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Angelita T. Pacion</i> M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Still Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>2-2-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ANGELITA T. PACION</i> | | | | | | | | 23D. ADDRESS <i>Women's Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 24B. DATE <i>2-4-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Dulaney Valley Memorial</i> | | 24D. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1965</i> | | | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | | | 25C. FUNERAL DIRECTOR <i>Brooks Funeral Service, Towson, Md. 21204</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | 65 1314 | |
| BIRTH NO. 65 1314 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) James Matthews. | | 2. DATE AND HOUR OF DEATH February 1, 1965 8:50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Memorial Nursing Home 27 N. Carey Street. Baltimore, Md. 21223. | | A. STATE MD B. COUNTY 22-02 | | | |
| 5. SEX M | | 6. RACE C | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH 1/23/00 | | 9. AGE (In years last birthday) 65 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME UNK | | 14. MOTHER'S MAIDEN NAME UNK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Lincoln Memorial Nursing Home | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 1963 19 65 to Feb. 1965 that (I) (we) last saw the deceased alive on Jan 31 19 65 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. R. Johnson M.D. | | 23B. DATE SIGNED 2/1-65 | | 23C. PHYSICIAN'S NAME (Type) W. R. Johnson M.D. | |
| 23D. ADDRESS 403 McKelvey Bg | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 2-3-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary | | 24D. LOCATION (City, town, or county) (State) A. A. County Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Master & Son | |
| | | | | ADDRESS 916, Penna Ave | |



M 300

65 1315

BALTIMORE CITY HEALTH DEPARTMENT

65 1315

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DENNIS A. MOODY

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965

11:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

110 N. Stricker Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

110 N. Stricker Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2-18-1910

9. AGE (In years
last birthd.)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Dennis Moody

14. MOTHER'S MAIDEN NAME

Stella Moody

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II.

16. SOCIAL
SECURITY NO.

212-18-9518

17. INFORMANT

ADDRESS

Jennie Jenkins - 825 N. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Uremia
DUE TO severe acute and chronic
pyelonephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-2-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-5-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat'l

23D. LOCATION

Baltimore

(City, town, or county)

(State)

City, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 5 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Morton + Dyett F.H. 916 Penna Ave

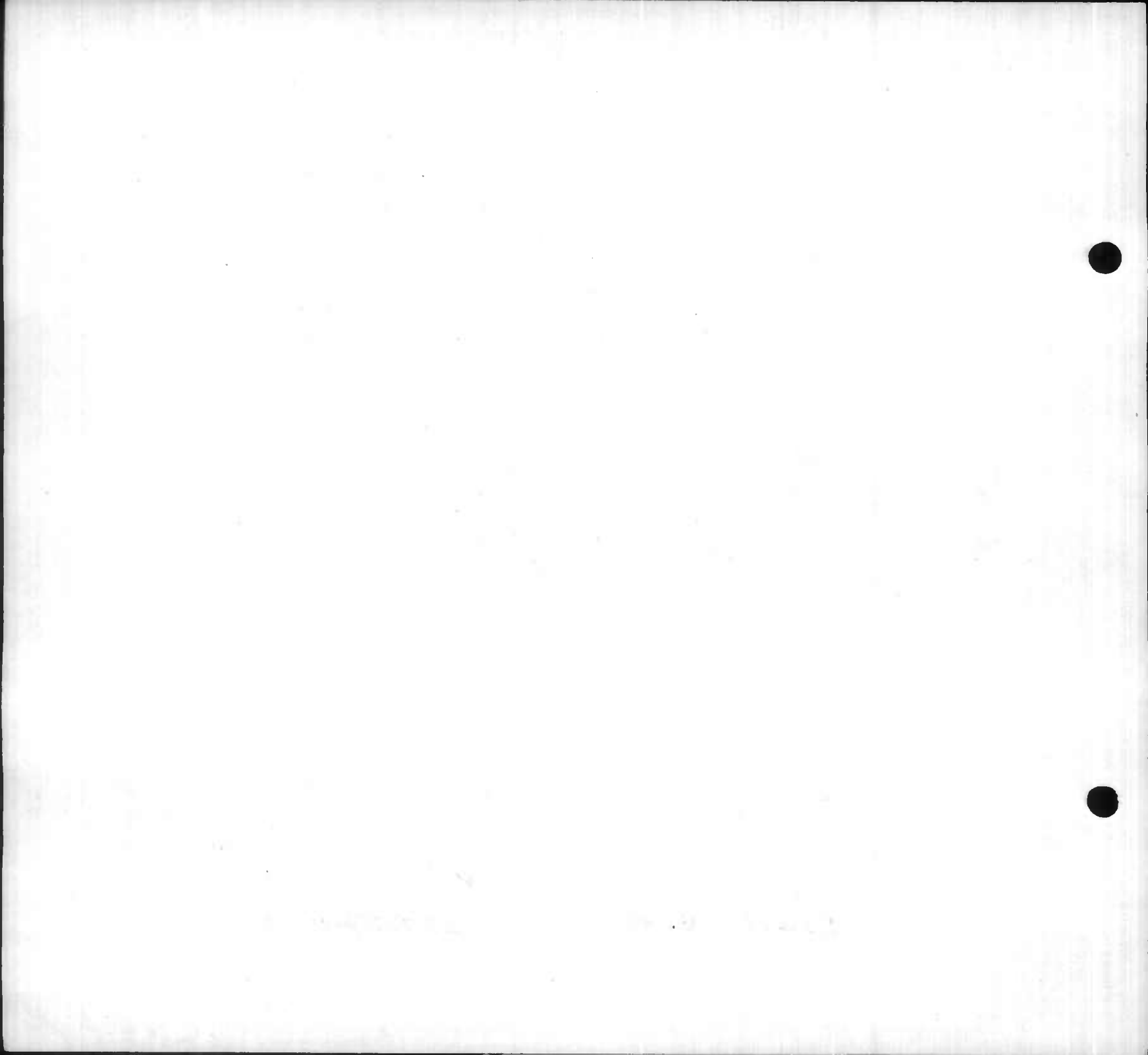
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1316 | |
|--|--|--|---|--|--|
| BIRTH NO. 65 1316 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) SARAH J. GRAY | | | 2. DATE AND HOUR OF DEATH 2/3/65 10 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 743 W. Cross St. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ind. B. COUNTY 21-01 | | |
| 5. SEX F | | | 6. RACE W | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | | | 8. DATE OF BIRTH 12/8/1897 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | |
| 10B. KIND OF BUSINESS OR INDUSTRY at home | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Frank P. Emrick | | | 14. MOTHER'S MAIDEN NAME Ella ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. — | | |
| 17. INFORMANT Shirley Gray (Sister) | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 350 X I | | | CAUSE OF DEATH (A) DUE TO Acute Cardiac Failure — one hour (B) DUE TO Paroxysm Agitation (C) 10 years | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 15, 1954 to Feb 3, 1965 , that (I) (we) last saw the deceased alive on Feb 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis J. Glass | | | | 23B. DATE SIGNED Feb 4, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) LOUIS J. GLASS | | | | 23D. ADDRESS 320 Patapsco Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/6/65 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Ind. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR John J. Cowan, Inc. 901 Halling St. Balt. 23, Ind. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|--|--|---|
| 65 1317 | | 65 1317 | | X | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Charles William Stuhr | | | 2. DATE AND HOUR OF DEATH Feb. 1, 1965 4pm | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lake Drive Nursing Home | | | Maryland Ann Arundel | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 52-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) 119 Reveria Drive | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED Widowed | 8. DATE OF BIRTH April 19, 79 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME George Stuhr | | 14. MOTHER'S MAIDEN NAME ? unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-01-2384 | | 17. INFORMANT ADDRESS Mrs. Ramona Fearins Mt. Wilson, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Chronic Brain Disease - yrs. | | | INTERVAL BETWEEN ONSET AND DEATH years | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Vascular Generalized | | | years | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic severe urinary tract infection | | | 2 yrs | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 15, 1962 to Feb. 1, 1965 , that (I) (we) last saw the deceased alive on Jan. 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis V. Blum M.D. | | | | 23B. DATE SIGNED Feb. 1, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Louis V. Blum | | | | 23D. ADDRESS 3502 W. Rogers Ave., Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-4-1965 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24F. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hwy. (25) | |

Revised Edition

1111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65-111783 | | BALTIMORE CITY HEALTH DEPARTMENT | | Film G584, 10/25/83 | | Registered No. 14318 | |
|--|------------------|---|--|--|---|--|--------------------------|
| CERTIFICATE AMENDED | | | | CERTIFICATE AMENDED | | | |
| 1. NAME OF DECEASED (Type or Print) Martin Luther MILLER | | | | 2. DATE AND HOUR OF DEATH February 3 1965 8 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 20-03 | |
| 126 S. Monroe St. | | | | C. CITY OR TOWN BALTIMORE | | D. STREET ADDRESS 126 S. Monroe St. | |
| 5. SEX MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH March 1, 1889 | 9. AGE (In years) 76 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY INDUSTRIAL | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard T. Miller | | | 14. MOTHER'S MAIDEN NAME Ella J. Miller | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 236-14-7497 | | 17. INFORMANT Elizabeth Cain | | ADDRESS 126 S. Monroe St. | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) <u>Atherosclerotic Heart Disease</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1963 to February 3 1965, that (I) (we) last saw the deceased alive on February 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Morris B. Schreiber | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER | | | | 23D. ADDRESS 15794 Lombard St. Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-6-65 | | 24C. NAME OF CEMETERY or CREMATORY MT. TABOR | | 24D. LOCATION (City, town, or county) (State) BERKELEY Springs W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR GEO. L. SCHWAB FUNERAL HOME Francis St. Miller 2101 Frederick Ave. | | | |



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65 1319

BALTIMORE CITY HEALTH DEPARTMENT

65 1319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

| | | | |
|--|--|---|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| LEROY THORNTON | | January 30, 1965 11:20 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL | | A. STATE Maryland B. COUNTY Baltimore | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 1320 Pennsylvania Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | Negro | Married | May 30, 1920 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| Construction | | Construction Worker | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| virginia | | U. S. A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Lindsay Thornton | | Florence Lee | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | | |
| 17. INFORMANT | | ADDRESS | |
| Pearl White | | 611 M Street NW, Washington, D.C. | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| Active pulmonary tuberculosis, moderate | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 2 | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED | |
| John E. Adams, M.D. | | 1-31-65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| Burial | Feb. 6-1965 | | Leesburg, Virginia |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR ADDRESS | |
| FEB 5 1965 | Robert E. Garvey, M.D. | Hart Bros. Funeral Home 621 Fla. Ave. N.W. Washington D.C. | |

MEDICAL CERTIFICATION

WALTER J. DUNN

WALTER J. DUNN

WALTER J. DUNN

WALTER J. DUNN

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65 1320

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1320

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BENJAMIN D GALLANT

2. DATE AND HOUR PRONOUNCED DEAD

January 23, 1965 7:35 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

2-02

D. STREET ADDRESS (If rural, give location)

233 S DURHAM ST

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

JUNE 9 1911

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

MISTICK STEAMSHIP

11. BIRTHPLACE (State or foreign country)

CANADA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS GALLANT

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

WORLD WAR II

16. SOCIAL
SECURITY NO.

109-03-4330

17. INFORMANT

ADDRESS

WILLIAM J FRENCH 233 S DURHAM ST

18.

490X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Bilateral Lobar Pneumonitis.

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/24/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

FEB 4 65

23C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL

23D. LOCATION

(City, town, or county)

(State)

FREDERICK RD MD

24A. DATE REC'D BY HEALTH DEPT.

FEB 5 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Dupont Bldg 1800 E LOMBARD

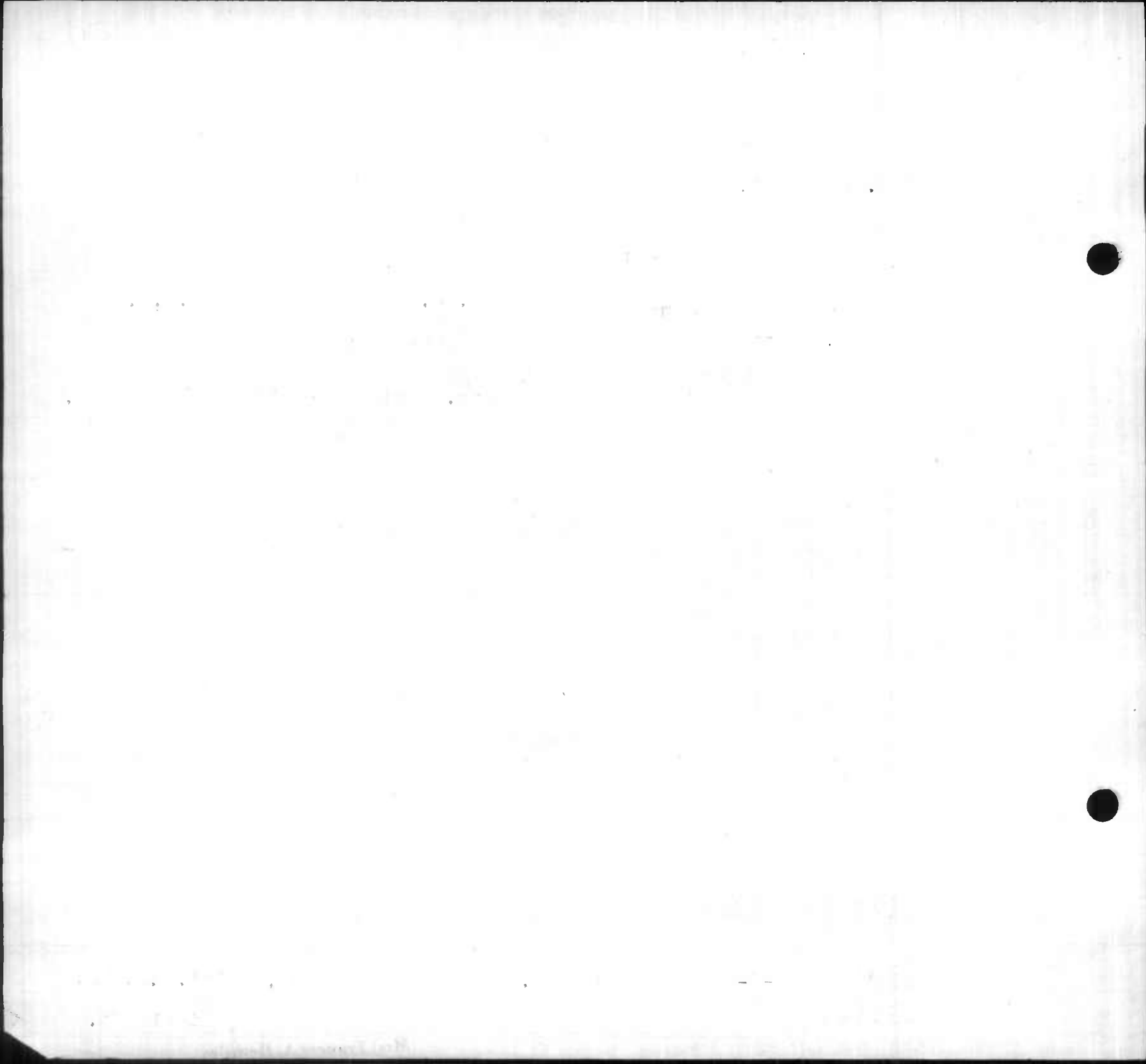
WALLACE COLLEGE

Class of 1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|-------------------------------------|---|---|
| BIRTH NO. 65 1321 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1321 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Dorey S. Paschall</u> | | 2. DATE AND HOUR OF DEATH <u>2/3/65 2:30 PM</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>13-01</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>27 N. Carey St.</u> | | D. STREET ADDRESS (If rural, give location) <u>818 Brooks Lane</u> | | E. AGE (In years last birthday) <u>86</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>3-7-1878</u> | 9. AGE (In years last birthday) <u>86</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>N. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Thomas Paschall</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Mamie Paschall 818 Brooks La.</u> | |
| 18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular Disease</u> | | CAUSE OF DEATH <u>Cardiovascular Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>10-21-64</u> 19 <u>65</u> to <u>Feb 3</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Feb 3</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <u>Robert E. Johnson</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>2-3-65</u> | |
| 23C. PHYSICIAN'S NAME (Print) <u>Robert E. Johnson</u> | | 23D. ADDRESS <u>403 Medford St</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 24B. DATE <u>2-6-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Arbutus, Balt. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Frances A. Hemley</u> | |
| 25D. ADDRESS <u>578 W Biddle St.</u> | | 25E. ADDRESS <u>578 W Biddle St.</u> | | 25F. ADDRESS <u>578 W Biddle St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1322 | |
|--|-----------------------------|---|--|---|--|
| BIRTH NO. 65 1322 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) BACKERT, MARGARET Elizabeth | | | February 1, 1965 11:45 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | | A. STATE Md. B. COUNTY 2603 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13 | | |
| | | | D. STREET ADDRESS (If rural, give location) 3813 Belair Road #13 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 10/29/97 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Frank Pfister | | | 14. MOTHER'S MAIDEN NAME Genevieve ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT (son) Edward Backert Rt. 2, Box 33 Fallston, Md. | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 1 19 65 to Feb. 1 19 65 , that (I) (we) lost saw the deceased alive on Feb. 1, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fausto Q. Aquino, Jr. M.O. | | | | 23B. DATE SIGNED 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) Fausto Q. Aquino, Jr. M.D. | | | 23D. ADDRESS 1400 N. Caroline Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/5/65 | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane #13 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1323</u> | |
|---|-------------------------|--|------------------------------------|---|--|
| BIRTH NO. <u>65 1323</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>RENA F. SMITH</u> | | 2. DATE AND HOUR OF DEATH <u>2-2-65</u> <u>5:45am</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home & Hosp.</u> | | A. STATE <u>Md</u> B. COUNTY <u>26-07</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>625 S. Mason St #24</u> | | | |
| 5. SEX <u>Fem.</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>1-10-98</u> | 9. AGE (In years last birthday) <u>67</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>James Gibson</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Horace E. Smith, husband, above</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute Coronary Insufficiency 2h</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Shock 20 to 4h</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>ASHD</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3:10 am</u> 19 <u>65</u> to <u>5:45 am</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Antoine Arrage</u> | | | | 23B. DATE SIGNED <u>2-2-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ANTOINE ARRAGE M.D.</u> | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/5/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley M.A.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc. 3331 Brehms Lane</u> | |

42-64-94 AM 1

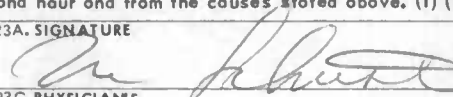
FUNERAL DIRECTOR: IMPORTANT

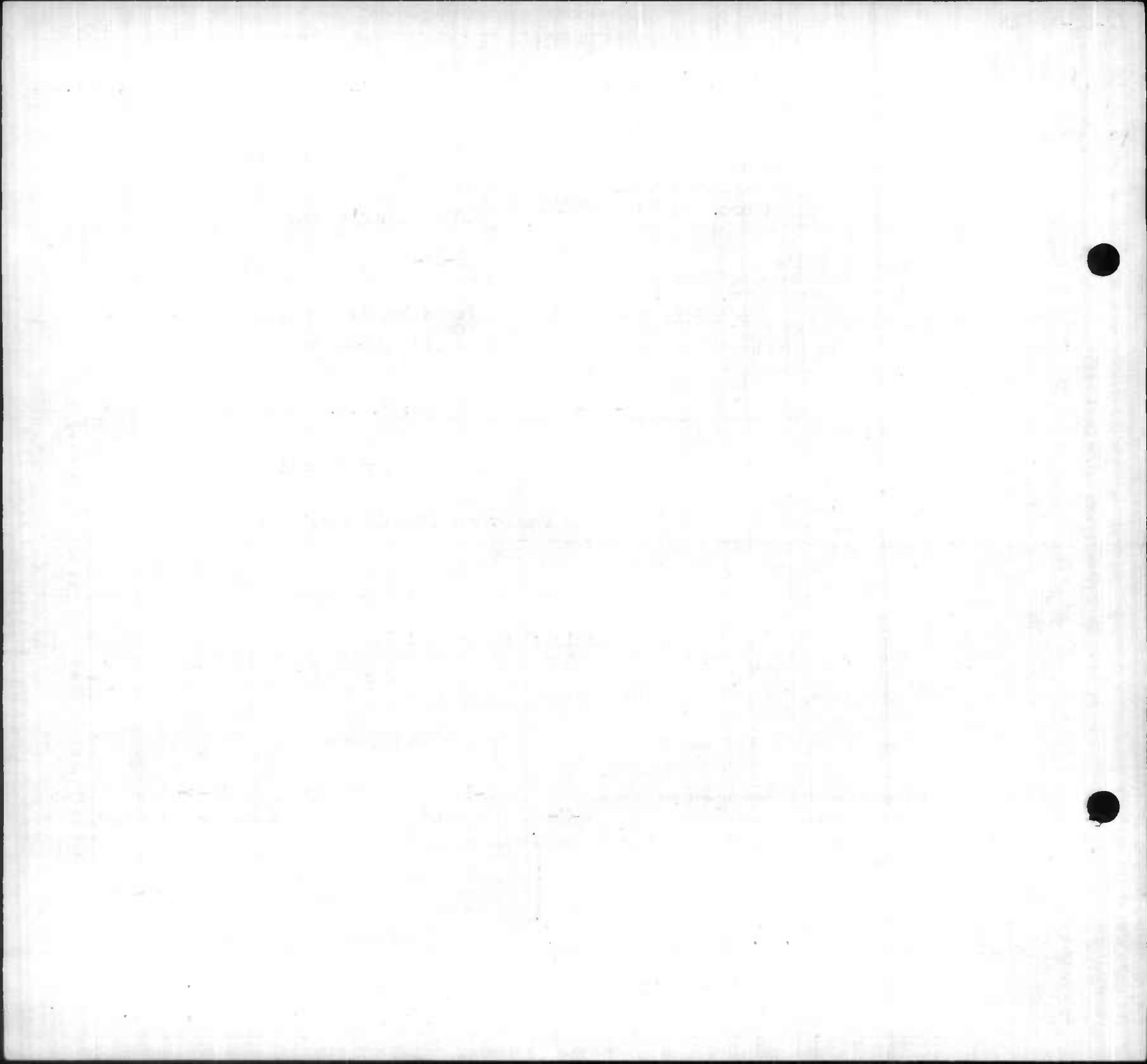
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1324

| | | | | | |
|--|---------|--|------------------|--|----------------------------------|
| BIRTH NO. 65 1324 | | M.E. CASE NO. J. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Mary Kelleher | | 2-2-65 8:45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1053 Horner's Lane | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| Female | White | Married | 11-18-90 | 74 | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housekeeper | | John Groeninger | | Pennsylvania | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Noel | | Elizabeth ? | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 212-20-4065 | | RECORDS: B.C.H. 4940 Eastern Avenue #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Rule Out Pulmonary Emboli DUE TO | | | |
| | | (B) Transverse Colonic Carcinoma DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Aspiration Pneumonitis | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (APPROX.) | | White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-19 19 65 to 2-2- 19 65, that (I) (we) last saw the deceased alive on 2-2- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
|  | | | | 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. M. Schuster | | 4940 Eastern Avenue #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/6/65 | | Holy Redeemer Cemetery | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 5 1965 | | Robert E. Taylor, M.D. | | Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1325 | |
|--|---|--|--|--|----------------------------|--|-----------------------------|
| BIRTH NO. 65 1325 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH February 3, 1965 9:05a M. | | | |
| 1. NAME OF DECEASED (Type or Print) McCray, Acie | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1304 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore 17, Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2802 Auchentoroly Terrace | | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) unknown | 8. DATE OF BIRTH May 8, 1908 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN - HOME | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) CHADBOURN, N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNK. | | 14. MOTHER'S MAIDEN NAME LUCY | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Annie Thronhill, sister 2903 Parkwood Ave. | | | | | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Hypertensive cardiovascular disease DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 2-1-65:2-3-65 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Edema | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 1, 1965 to February 3, 1965 , that (I) (we) last saw the deceased alive on February 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ruperto M. Manankil | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23D. ADDRESS 1514 Division St. - Baltimore, Maryland | | | | 23B. DATE SIGNED February 3, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-6-65 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS 1637 Druid Hill Ave. | | | |



2-4
42-55-85 AM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 1326

BIRTH NO. 65 1326

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) **THOMAS ALFONSE NICHOLS**
(ALIAS **Alfred Nicholas**)

2. DATE AND HOUR OF DEATH
2-1-65 **6:15 P.** M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY **7-03**
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
504 North Patterson Park Avenue

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Divorced** 8. DATE OF BIRTH **1-3-22** 9. AGE (In years last birthday) **43** 10. If Under 1 Yr. Months: Days: Hours: Min. 11. If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **MACHINIST** 10B. KIND OF BUSINESS OR INDUSTRY **HOME IMPROVE.** 11. BIRTHPLACE (State or foreign country) **New York PA.** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **AUGUST P. NICHOLS** 14. MOTHER'S MAIDEN NAME **HELEN POUCHROWSKI**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS **RECORDS: B.C.H. 4940 Eastern Avenue**

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) **Anaplastic Carcinoma Metastatic from Lung.**
(B) DUE TO
(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Congestive Failure

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At ☐ Not While At ☐ Work 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **1-8-** **19 65** to **2-1** **19 65**, that (I) (we) last saw the deceased alive on **2-1** **19 65** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Dr. M. Schuster** M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED **2-1-65**

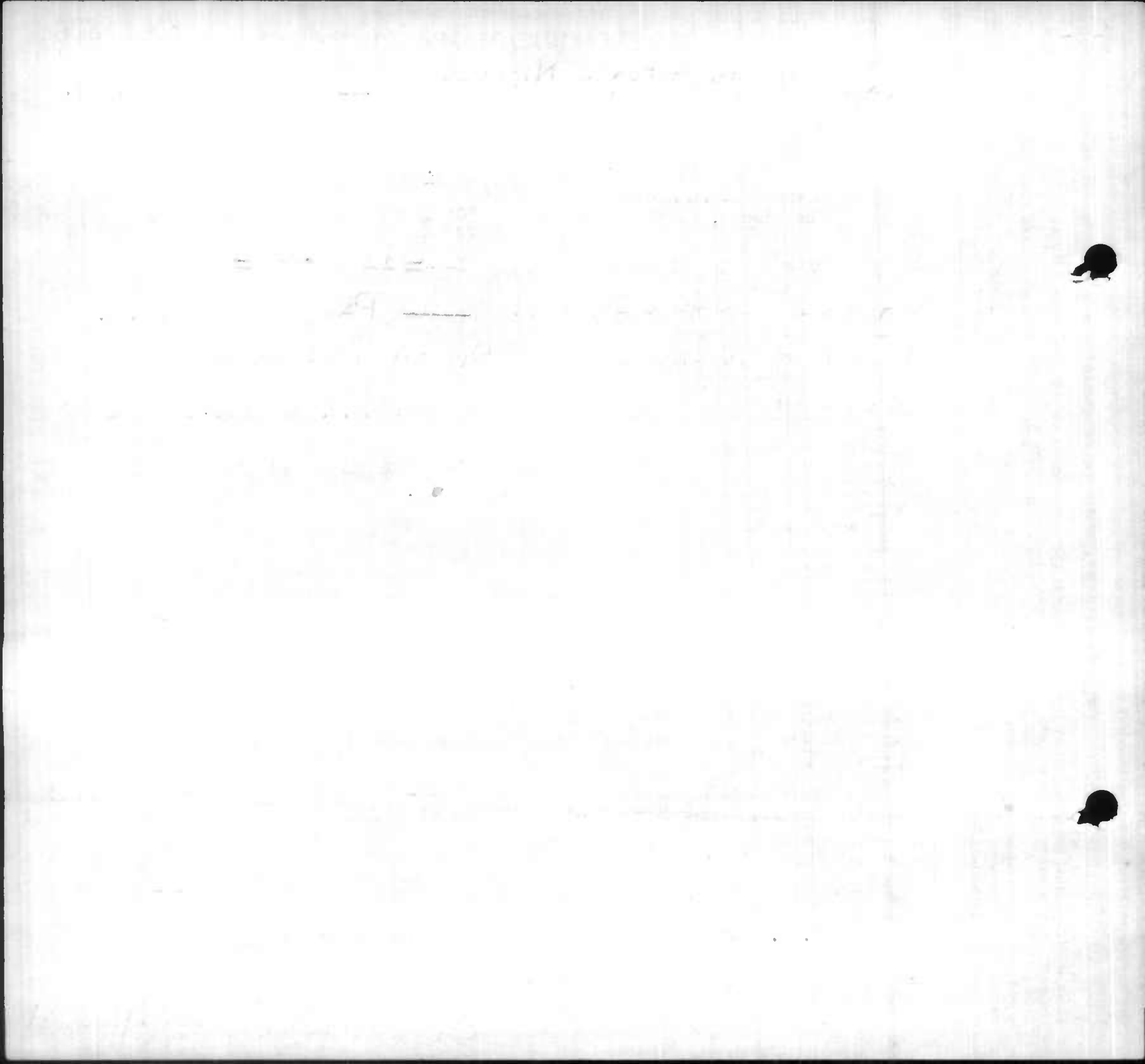
23C. PHYSICIAN'S NAME (Type) **Dr. M. Schuster** M.D. 23D. ADDRESS **4940 Eastern Avenue #21224**

24A. BURIAL CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **1-3-65** 24C. NAME OF CEMETERY OR CREMATORY **MT. CARMEL CEM.** 24D. LOCATION (City, town, or county) (State) **BALTO., MD.**

25A. DATE REC'D BY HEALTH DEPT. **FEB 5 1965** 25B. NAME OF REGISTRAR **Robert E. Taylor M.D.** 25C. FUNERAL DIRECTOR ADDRESS **Harley Miller - 2334 Jefferson St.**

FUNERAL DIRECTOR: IMPORTANT

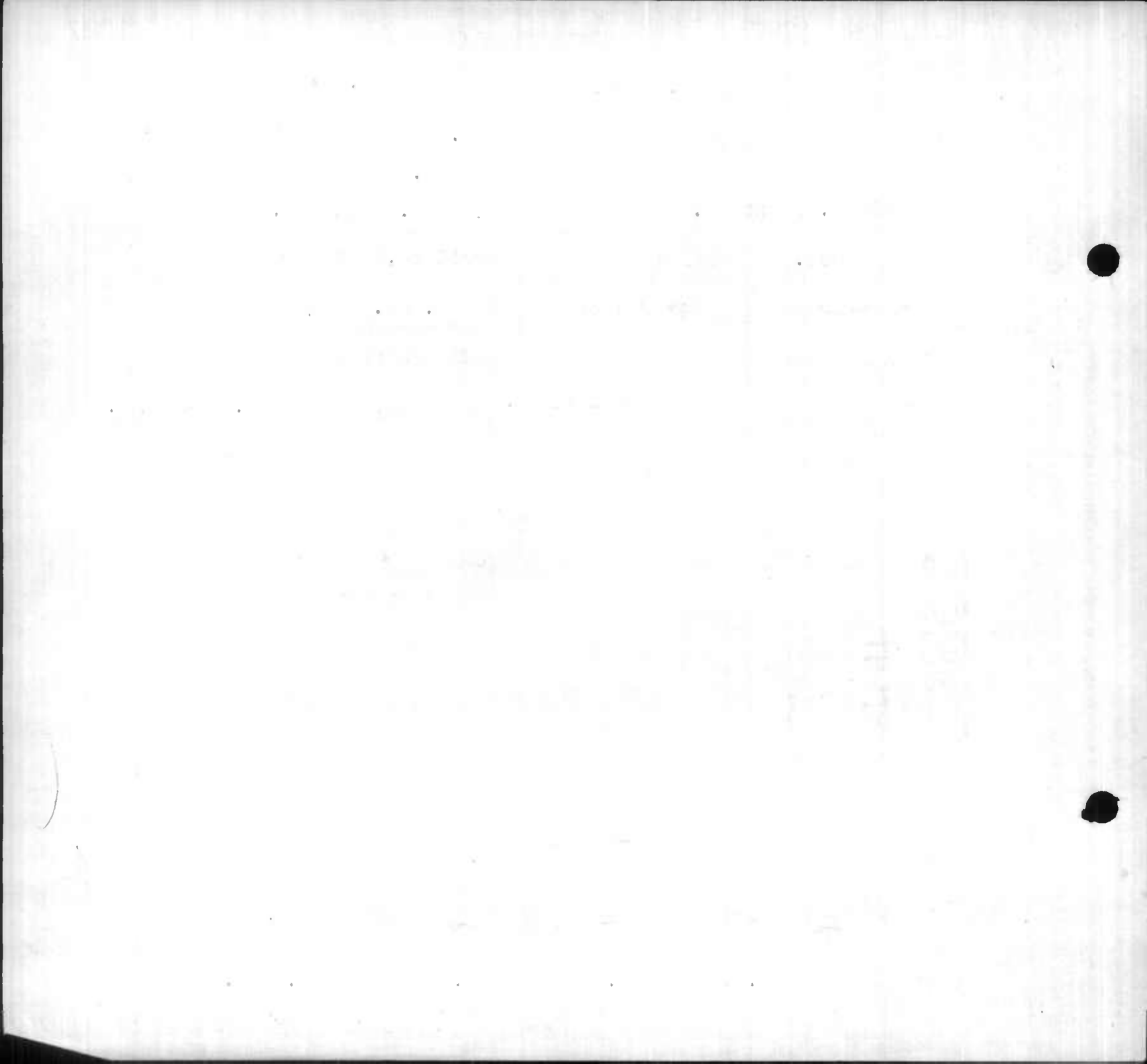
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1327 | |
|---|--|--|--|--|---|---------------------------------------|--|---------------------------------|--|---|--|
| BIRTH NO. 65 1327 | | | | | | | | | | M. | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | CLARENCE M. BIDDLE | | | | | 2. DATE AND HOUR OF DEATH FEB. 2, 1965 1:30 A. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | | (If not in hospital or institution, give street address or location) | | | | | Md. 15-02 | |
| 1524 N. Mount St. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | Balto. | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | | 1524 N. Mount St. | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | |
| Male | | Col. | | Married | | April 14, 1905 | | 59 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | | | | Box factory | | | | | Balto. Md. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| Charles Biddle | | | | | Sadie Frazier | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| no | | | | | 215-05-1900 | | Hilda Biddle 1524 N. Mount St. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 442X I | | | | | Respiratory failure | | | | | | |
| ANTECEDENT CAUSES | | | | | Hypertensive Cardiovascular | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | Renal disease | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to 2/2 1965. | | | | | | | | | | | |
| that (I) (we) last saw the deceased alive on 2/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | | | |
| J. Borotsky | | | | | 2/4/65 | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | | |
| J. Borotsky | | | | | 601 N. Mount St. Balto. Md. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | 24E. FUNERAL DIRECTOR | | ADDRESS | |
| Burial | | Feb. 5, 1965 | | Mt. Auburn Cem. | | Balto. Md. | | Williams Funeral Home | | 319 N. School St. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR | |
| FEB 5 1965 | | | | | Robert E. Taylor, M.D. | | | | | Williams Funeral Home | |



1
T 460

65 1328

BALTIMORE CITY HEALTH DEPARTMENT

65 1328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARIE TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

February 3, 1965

1:50 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1329 W. Lafayette Avenue

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

AUG-3-1901

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

Put Family

11. BIRTHPLACE (State or foreign country)

RICHMOND VA

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JOHN B. RICHARDSON

14. MOTHER'S MAIDEN NAME

BOLLO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-36-0720

17. INFORMANT

ADDRESS

FERNST WOODS 1329 W. LAFAYETTE AVE

18.

792 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Uremia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-3-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/6/65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 5 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Margaret P. Hays 634 N. GILMOR

ADDRESS

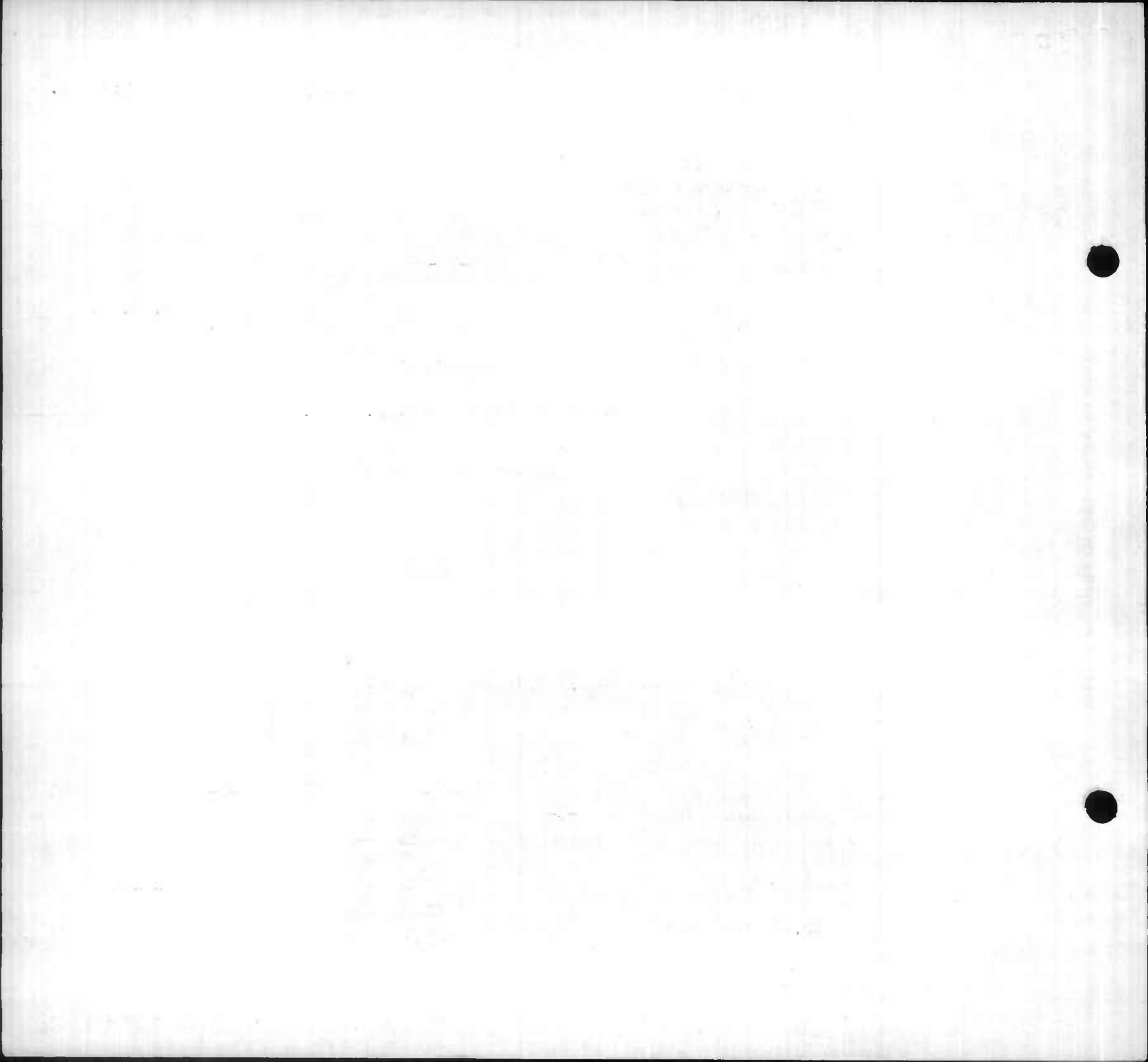
WILLIAM J. HARRIS

Wm. J. Harris
Wm. J. Harris

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

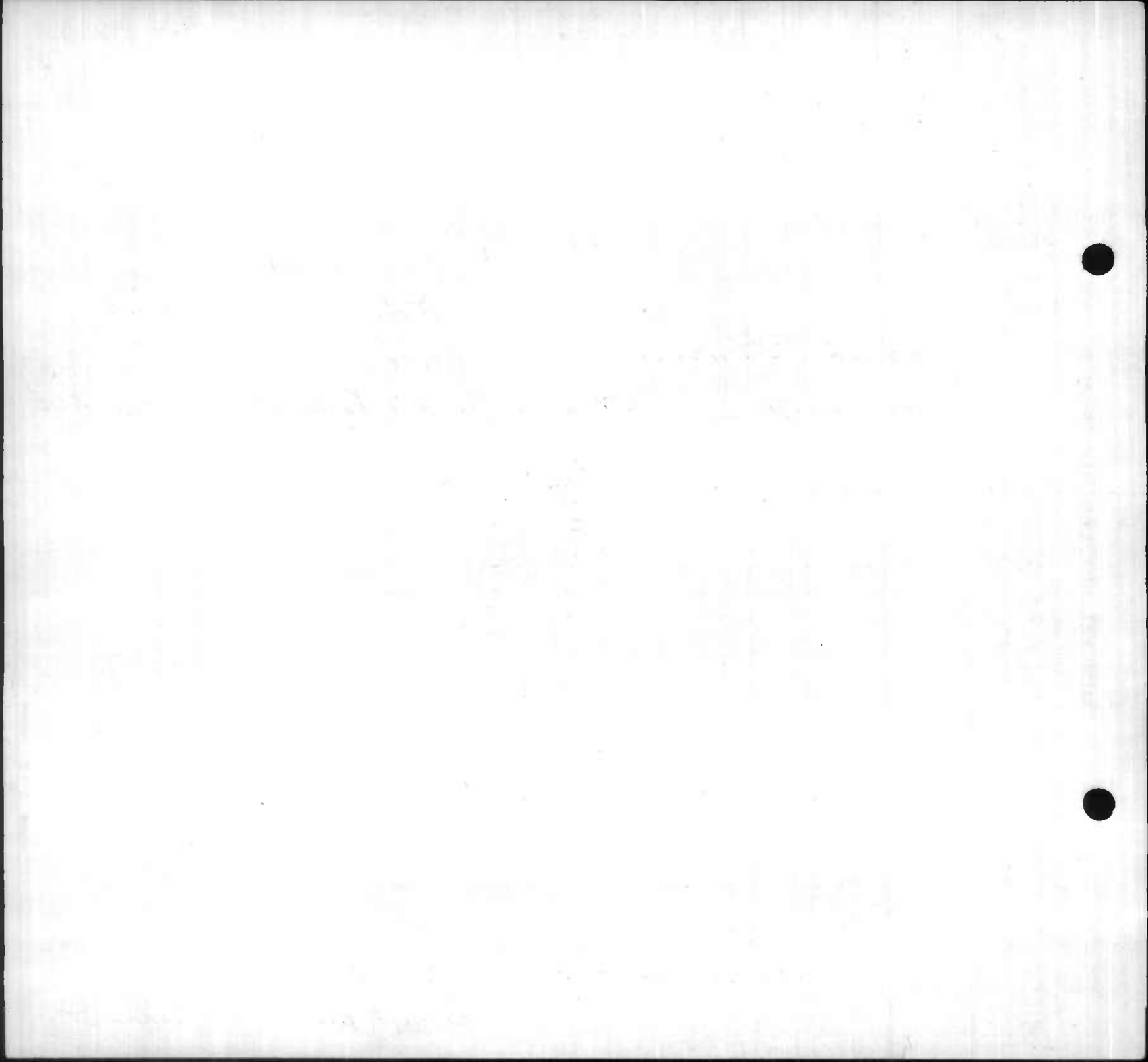
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1329</u> | |
|---|-------------------------|---|------------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. <u>65 1329</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | <u>Klein Leavey</u> | | <u>2-3-65</u> <u>8:35 A. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>2831</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>5526 Nome Avenue</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>6-31-87</u> | 9. AGE (In years last birthday) <u>77</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>CITY</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH - LEAVEY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>IDA ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-10-4998</u> | | 17. INFORMANT ADDRESS <u>RECORDS: B. C. H. 4940 Eastern Avenue #21224</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration Pneumonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>January 29</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Benign Prostatic Hyperplasia</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-28-</u> <u>19 64</u> to <u>2-3-</u> <u>19 65</u> , that (I) (we) last saw the deceased alive on <u>2-3-</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Richard Lane</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>2-3-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard Lane</u> | | | | 23D. ADDRESS M.D. <u>4940 Eastern Avenue #21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-4-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MT. CARMEL</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR <u>Jack Lewis Inc</u> | | ADDRESS <u>2100 EUTAW PL.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

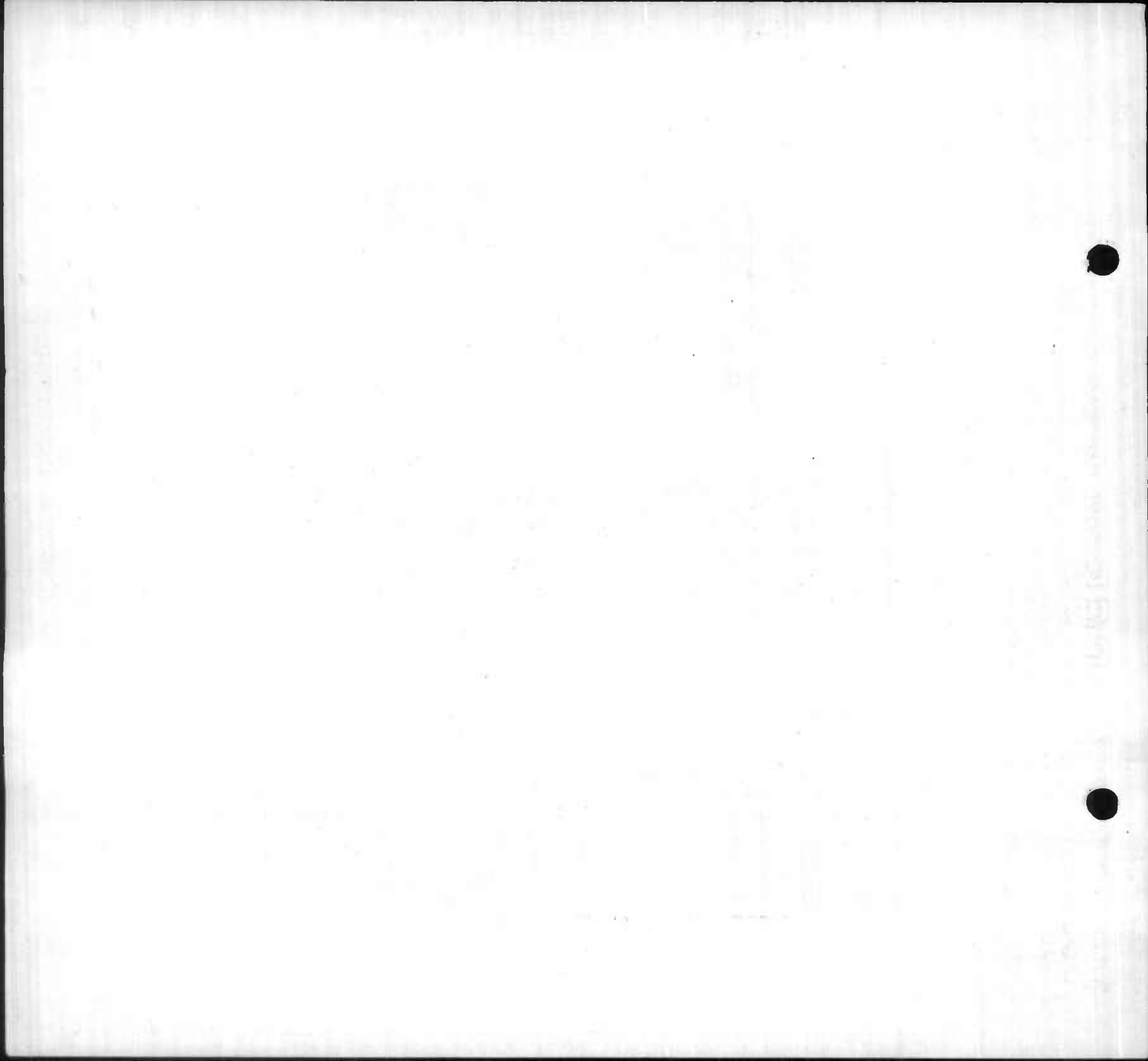
| BIRTH NO. 65 1330 | | | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 65 1330 | |
|--|-----------|--|--------------------------|--|------------------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) DANIEL L. JOHNSON | | | | 2. DATE AND HOUR OF DEATH 2/4/65 2 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-16 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2817 OAKFORD AVE. | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 11/6/13 | 9. AGE (In years lost birthdgy) 51 | 10. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Isiah Johnson | | | | 14. MOTHER'S MAIDEN NAME Nellie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 578-36-5920 | | 17. INFORMANT ADDRESS Minnie Feller 2817 Oakford Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) TUMOR (A) ESOPHAGEAL ACUTE UPPER GASTROINTESTINAL HEMMORRAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/4/1965 to 2/4/1965, that (I) (we) last saw the deceased alive on 2/4/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Peter Papastamoy M.D. | | | | 23B. DATE SIGNED 2/4/65 | | 23C. PHYSICIAN'S NAME (Type) PETER PAPASTAMOY M.D. | |
| 23D. ADDRESS SINAI HOSPITAL | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 2-5-65 | | 24C. NAME OF CEMETERY or CREMATORY Bg Ho. Nch. Cem. | | 24D. LOCATION (City, town, or county) Baltimore, Md | | 24E. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Varney M.D. | | 25C. FUNERAL DIRECTOR ADDRESS George A. Kelen 1348 N. Calhoun St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1331 | |
|---|---------------------|---|------------------------------------|---|--|
| BIRTH NO. 65 1331 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>WILLIAM PATRICK SOFSKY</u> | | 2. DATE AND HOUR OF DEATH <u>4 FEBRUARY 1965</u> <u>1145</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> | | D. STREET ADDRESS (If rural, give location) <u>6206 CATALPA ROAD</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>7-15-01</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SHIPYARD</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>FRANCIS A. SOFSKY</u> | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE MCGAINEY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u> | | 16. SOCIAL SECURITY NO. <u>UNK</u> | | 17. INFORMANT <u>F.O. SMITH, MD</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary arteriosclerosis</u> <u>acute obese, severe</u> <u>congestive heart failure</u> <u>Chronic pneumonia</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>1 FEB 65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>EMBOLUS @ femoral artery</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> <u>N/A</u> | | 21F. HOW DID INJURY OCCUR? <u>N/A</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>23 JANUARY</u> 19 <u>65</u> to <u>4 FEBRUARY</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4 FEBRUARY</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Frederick O. Smith</u> | | | | 23B. DATE SIGNED <u>4 Feb 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FREDERICK O. SMITH</u> | | | | 23D. ADDRESS <u>Union Memorial Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/8/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ST. MARYS -</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>GOVANS. -</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | |
| 25C. FUNERAL DIRECTOR <u>Spitzfeld, Sam - 501/2525</u> | | 25D. ADDRESS <u>Spitzfeld, Sam - 501/2525</u> | | | |



1

65 1332

BALTIMORE CITY HEALTH DEPARTMENT

65 1332

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES PRIHODA, SR.

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965 8:50 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1445 Lowman St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

8 - 3 - 1882

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Austria

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Prihoda

14. MOTHER'S MAIDEN NAME

Mary Jucuek

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-0641

17. INFORMANT

ADDRESS

Frances Malkinski 1503 E. Clement St.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-3-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/6/65

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 5 1965

24B. NAME OF REGISTRAR

Robert E. J. J. J.

24C. FUNERAL DIRECTOR

ADDRESS

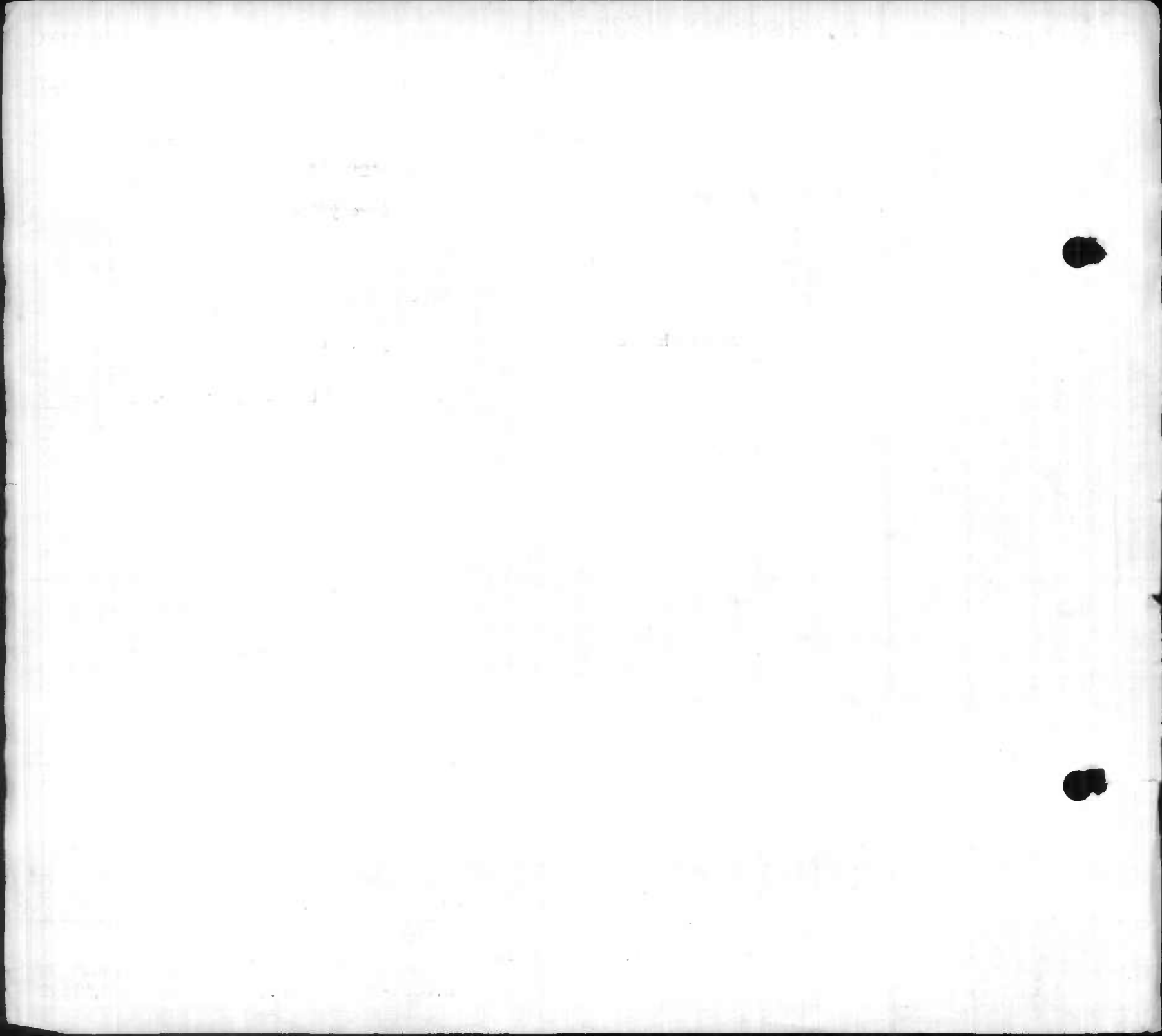
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Ave.

WALTER BOWEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

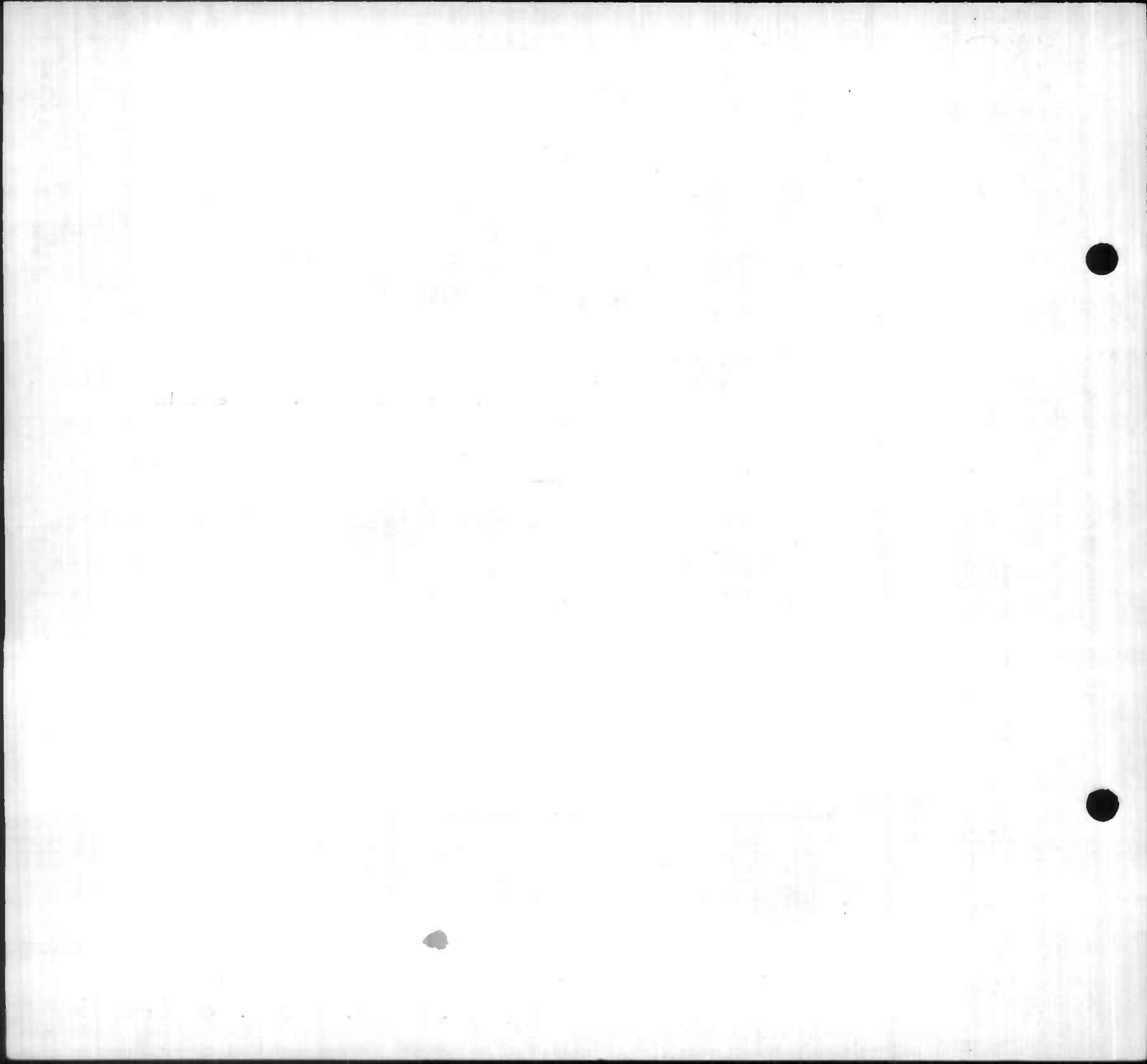
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|---------------------|--|---|--|-----------------------------------|--|---------------------------------|--|--|--|-----------------------------|--|--|
| BIRTH NO. 65-03519 65 1333 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1333 | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) BABY GIRL THORNTON | | | | | | | | | | LAURA ANN | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | | | | | | | | A. STATE Maryland | | | | |
| | | | | | | | | | | B. COUNTY Balto | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21236 | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 8012 Ridgely Road | | | | |
| 5. SEX F | | 6. RACE C | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single | | 8. DATE OF BIRTH 2-3-65 | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| | | | | | | | | | | 1 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | 13. FATHER'S NAME Edward Arnold Thornton | | | | | 14. MOTHER'S MAIDEN NAME Mary p. Reuling | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS Edward Arnold Thornton, 8012 Ridgely Road | | | | |
| 18. 771.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Pulmonary hemorrhage and atelectasis (B) And (C) atelectasis INTERVAL BETWEEN ONSET AND DEATH 18 hours | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 3 1:30 pm 19 65 to Feb 4 19 65 , that (I) (we) last saw the deceased alive on Feb 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Imelda R. Salanis | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | |
| 23B. DATE SIGNED 2-4-65 | | | | | | | | | | 23C. PHYSICIAN'S NAME (Type) Mercy Hospital Balto. Md 21202 | | | | |
| 23D. ADDRESS | | | | | M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 2-6-65 | | | | | 24C. NAME of CEMETERY or CREMATORY Finksburg Cemetery | | | | |
| 24D. LOCATION (City, town, or county) (State) Finksburg, Md | | | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | | | |
| 25C. FUNERAL DIRECTOR Wm. COOK-Towson, Inc., 1050 York Road, 21202 | | | | | ADDRESS | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

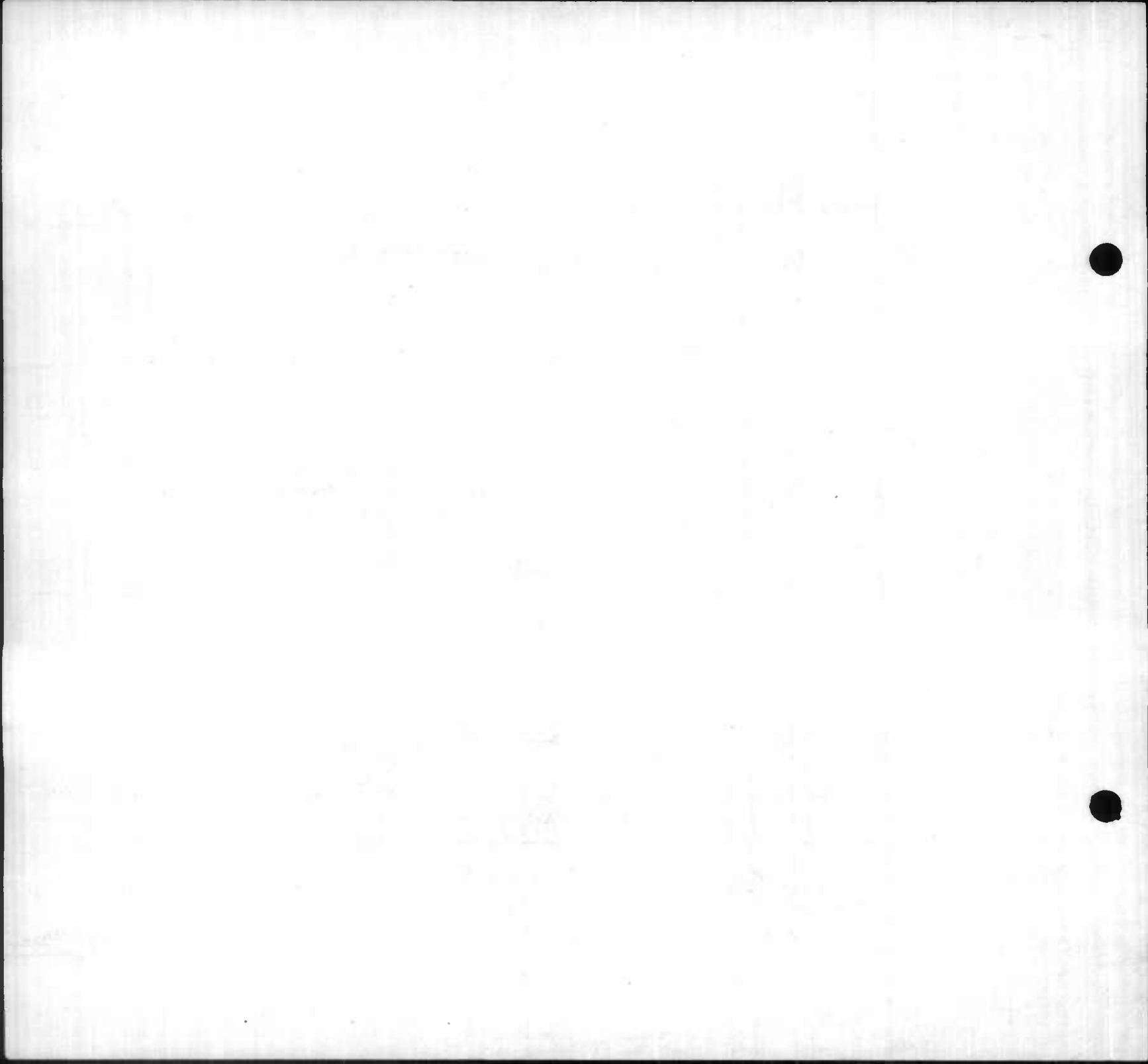
| BIRTH NO. 65 1334 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1334 | |
|---|-----------------------------|---|------------------------------------|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>C. EDWARD STORCK, Sr</u> | | | | 2. DATE AND HOUR OF DEATH <u>FEBRUARY 11, 1965 3:00 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> <u>Baltimore, Maryland</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>12-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21218</u> D. STREET ADDRESS (If rural, give location) <u>234 E. 25th ST.</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>CAUCASIAN</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>12-8-80</u> | 9. AGE (In years last birthday) <u>84 YEARS</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Lumber Dealer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | |
| 13. FATHER'S NAME <u>GEORGE I. STORCK</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JENNIE BARTH</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>C. Edward Storck, Jr., 112 Melahatchton Ave</u> | | | |
| 18. <u>491X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | | 19. <u>LEFT CEREBRAL THROMBOSIS</u> DUE TO <u>5 days</u> | | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 30</u> 19 <u>65</u> to <u>FEBRUARY 4</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 4</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Daniel Morritt Mac Millan</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2/4/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-8-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul Street, 21202</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1335 | |
|--|---|---|--|--|--|---|--|
| BIRTH NO. 65 1335 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | ELIZABETH J. PHIPPS | | | | 2. DATE AND HOUR OF DEATH 2/2/65 7:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2802 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | D. STREET ADDRESS (If rural, give location) 4203 SPRINGDALE AVE | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH DECEMBER 24, 84 | | 9. AGE (in years last birthday) 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME (unknown) Canapp | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS HOSPITAL ADMISSION RECORD | | | |
| 18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) GASTROINTESTINAL HEMORRHAGE DUE TO (B) ? CA OF STOMACH DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| MEDICAL CERTIFICATION | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD, Liver disease | | | | | |
| | | 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that he (this hospital) attended the deceased from January 27, 1965 to February 2, 1965 , that he (we) last saw the deceased alive on February 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Samuel Muher | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED February 2, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL MUHER | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-6-65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Carmel Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202 | | | |



H 200

65 1336

BALTIMORE CITY HEALTH DEPARTMENT

65 1336

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AMOS J. HIGGS

2. DATE AND HOUR PRONOUNCED DEAD

2-1-65 11:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

200 E. LAFAYETTE AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

200 E. Lafayette Avenue
Baltimore 21202

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed

8. DATE OF BIRTH

1896

9. AGE (In years last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Textile Worker

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Jacob Higgs

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
213-03-1984

17. INFORMANT ADDRESS
Nelson A. Higgs, 432 East 32nd St., 21218

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Old and fresh hematoma, left
~~XXXXXX~~
and meningioma, left

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema with congestive heart failure and acute ethylism

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
200 E. Lafayette Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year)
2 1 '65 AM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell - Striking face against front door knob or projectile

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-1-65

23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL

23B. DATE
2-5-65

23C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery

23D. LOCATION (City, town, or county) (State)
Woodlawn, Md

24A. DATE REC'D BY HEALTH DEPT.

FEB 5 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook, Inc., 1217 St. Paul Street, 21202

ADDRESS

WALLLEY POLICE

PAGE TWO

1
G. 450

65 1337

BALTIMORE CITY HEALTH DEPARTMENT

65 1337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEONARDO GIULIANO

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965

2:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1331 W. Mt. Royal Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Colonnade Hotel - 1331 W. Mt. Royal Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Divorced

8. DATE OF BIRTH

May 10, 1898

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Brick layer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF
WHAT COUNTRY?

Italy

13. FATHER'S NAME

Nicholas Giuliano

14. MOTHER'S MAIDEN NAME

Anntoenetti (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

052-12-6802

17. INFORMANT

ADDRESS

Leonard Giuliano. 2041 E. 31st Street Balto.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive & arteriosclerotic
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

m.

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-2-65

John E. Adams, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2-4-65

23C. NAME OF CEMETERY or CREMATORY

St. Paul's Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 5 1965

Robert E. Taylor, M.D.

Wm. Cook-Hamilton, Inc., 6009 Harford Rd

WALTER B. BROWN

1
K 400

65 1338

BALTIMORE CITY HEALTH DEPARTMENT

65 1338

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

| | | | |
|---|--|---|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| HOLLIS H. KELLEY | | February 4, 1965 12:55 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| Maryland General Hospital | | A. STATE Maryland B. COUNTY | |
| 5. SEX Male | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Widowed | | Oct. 11, 1897 | |
| 9. AGE (In years last birthday) | | If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min. | |
| 67 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| Storekeeper | | Rheem Mfg. Company | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Thebes, Illinois | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Vincent Kelley | | Ella Josephine (unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| YES WW II | | 324-14-4819 | |
| 17. INFORMANT | | ADDRESS | |
| Miss Mildred Sirt | | 849 Park Avenue, 21201 | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Charles S. Petty, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| BURIAL | 2-8-65 | Baltimore National | Baltimore |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR | ADDRESS |
| FEB 5 1965 | Robert E. Farley, M.D. | Wm. Cook, Inc., | 1217 St. Paul Street, 21202 |

VALLEY FORGE

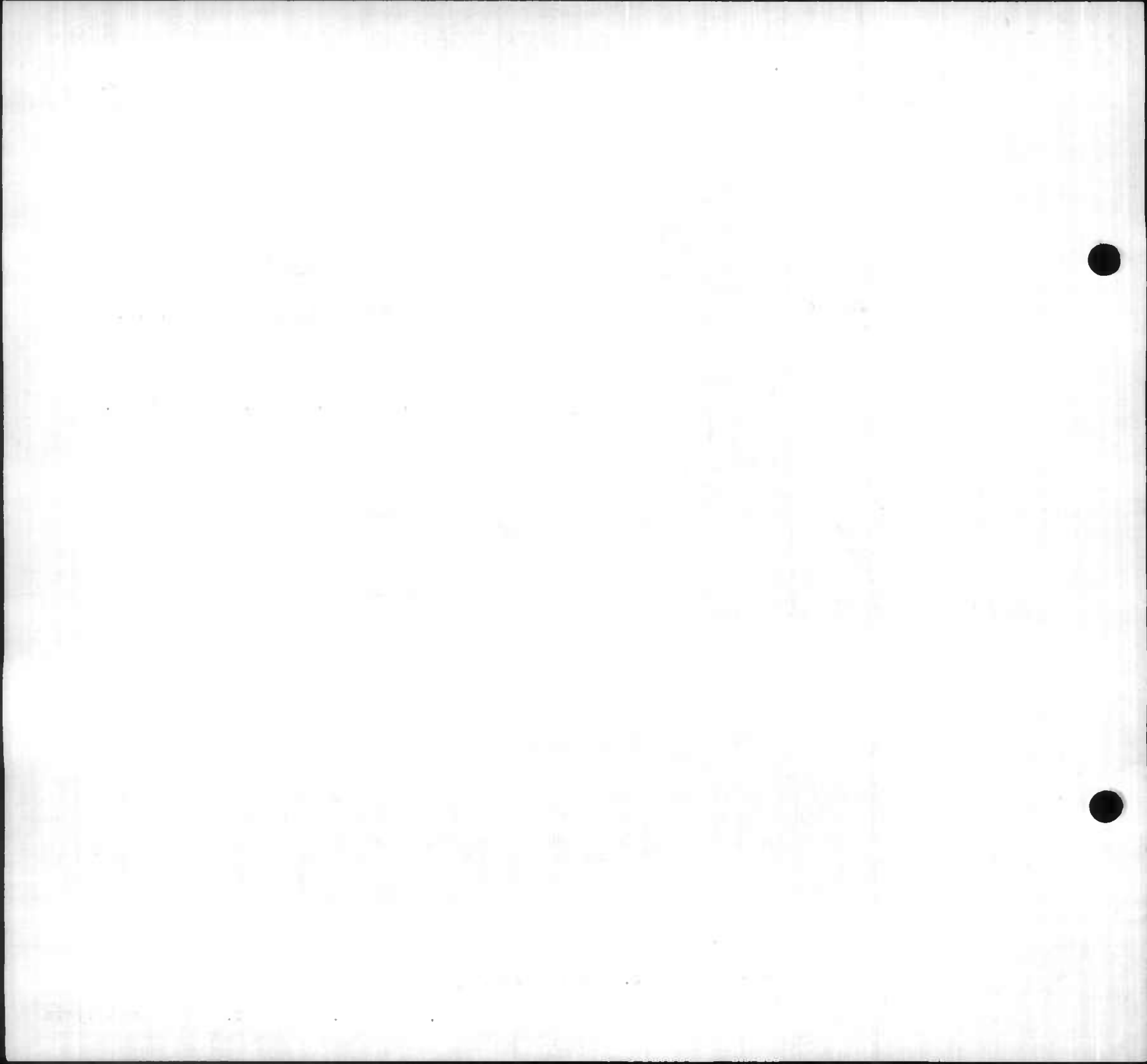
RECORDED

JA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

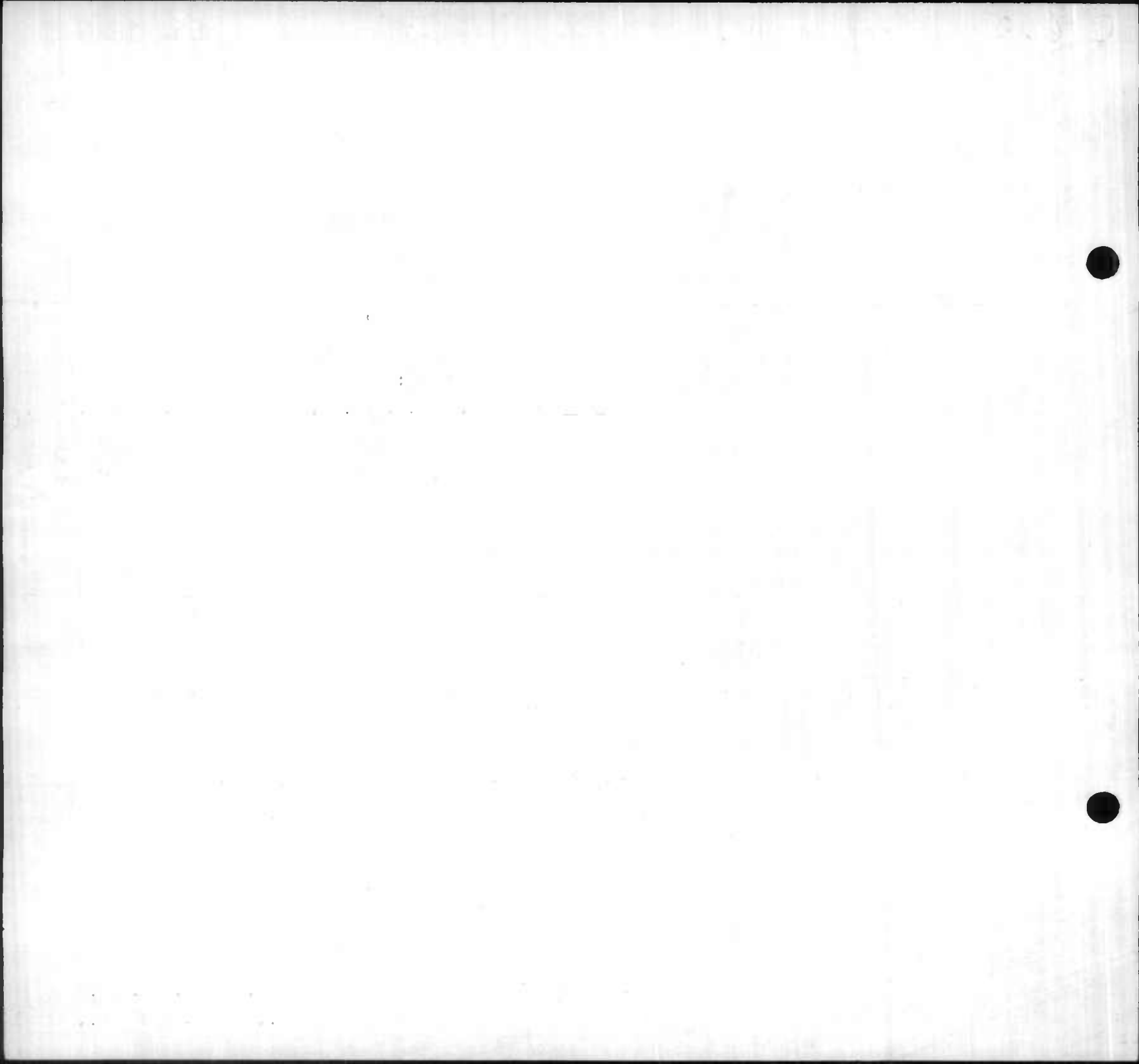
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------|--|--------------------------|---|---|
| BIRTH NO. 65 1339 | | CERTIFICATE OF DEATH | | 65 1339 | |
| M.E. CASE NO. N. | | 1. NAME OF DECEASED (Type or Print) IRENE REIMER | | 2. DATE AND HOUR OF DEATH 2-4-65 4.00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 6-04 | |
| 33 THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE CITY 21231 | |
| | | D. STREET ADDRESS (If rural, give location) | | 1926 EAST BALTIMORE STREET | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-31-03 | 9. AGE (In years last birthday) 61 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME HARRISON BOSTWICK | | 14. MOTHER'S MAIDEN NAME LOUISE WISLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Harry L. Riemeer. 1926 E. Baltimore St., 21231 | |
| 18. 330X 4-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Subarachnoid & intracerebral hemorrhage (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1d. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mild diabetes. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/3 19 65 to 2/4 19 65 that (I) (we) last saw the deceased alive on 2/4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Willis C. Maddrey | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/4/65 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIS C. MADDREY | | 23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-6-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

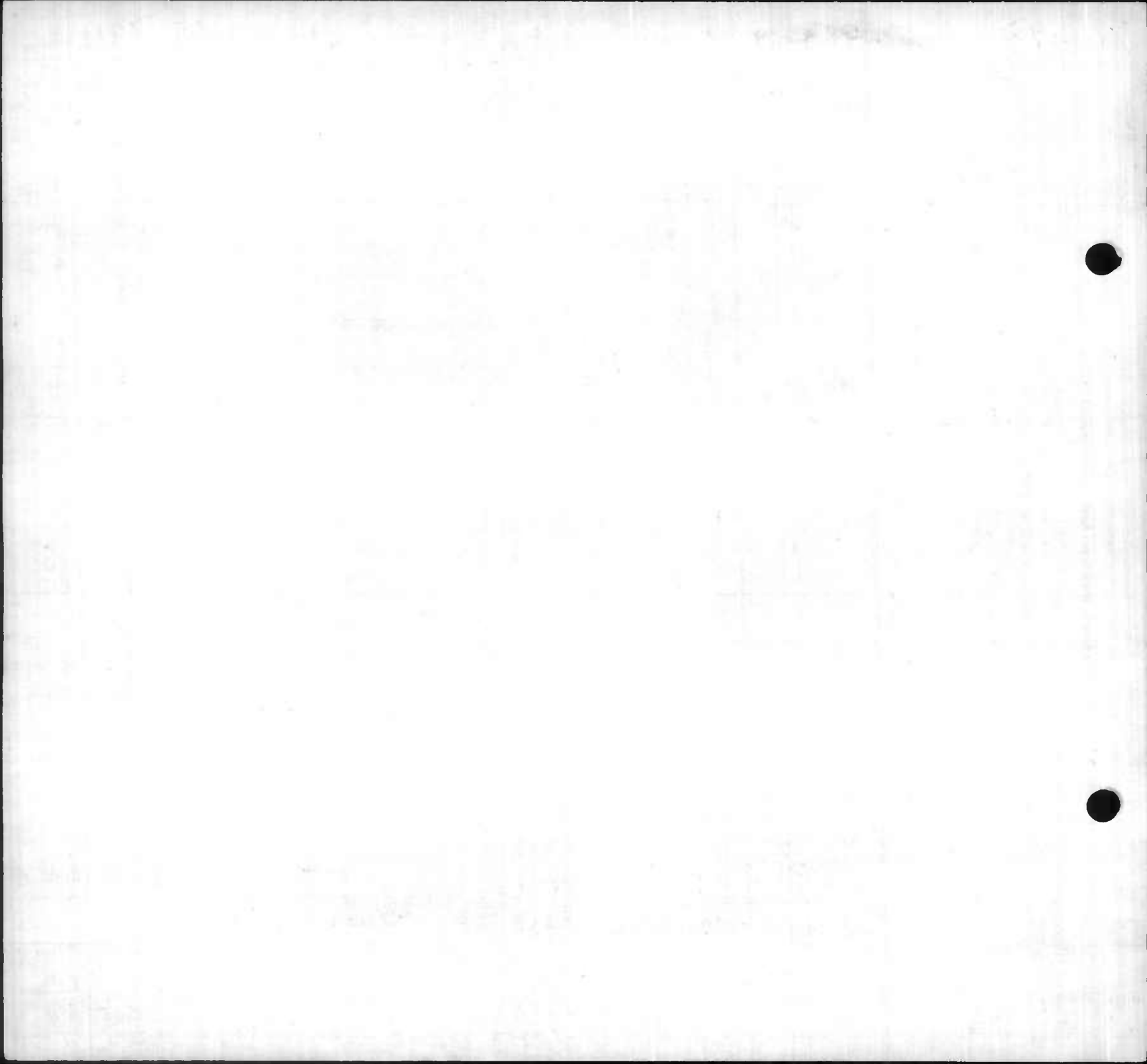
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|---|--|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1340 | | | | |
| BIRTH NO. 65 1340 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Cary Dorothy</i> | | | | | 2. DATE AND HOUR OF DEATH <i>2-5-65</i> <i>6:45</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>Maryland</i> B. COUNTY <i>12-01</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>221 Ridge Meade Rd.</i> | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>7-31-92</i> | 9. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>G. Edwin Dowell</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Nannie Winkle</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. <i>215-13-1735</i> | | 17. INFORMANT: <i>Cousin</i> ADDRESS <i>Mr. Geo. H. Dowell, 5015 Falls Rd. Terrace, City,</i> | | | | |
| 18. <i>570.5 I</i> CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Multiple old fistulae</i> | | | | | (A) DUE TO | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2/10/29/64</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>obstruction</i> | | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/29/64</i> to <i>2/5</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>2/5</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>John R. Wagner</i> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>2/5/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN R. WAGNER</i> M.D. | | | | | 23D. ADDRESS <i>The Johns Hopkins Hospital</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>2/3/1965</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Pikesville, Balto. Co. Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS <i>Stewart & Mowen Co., 108 W. North Av., City 1</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|-------------------|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1341 | |
| BIRTH NO. 65-04858 | | 65 1341 | | | | | | | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Mc Cullin Baby Boy</i> | | | | 2. DATE AND HOUR OF DEATH <i>1/31/65 1:20 PM</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore RANDALLSTOWN</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i> | | | | D. STREET ADDRESS (If rural, give location) <i>3713 SONARA RD. 5300</i> | | | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>—</i> | | 8. DATE OF BIRTH <i>1/31/65</i> | 9. AGE (In years last birthday) <i>—</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i> | | 11. BIRTHPLACE (State or foreign country) <i>—</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>9 8</i> | |
| 13. FATHER'S NAME <i>HORACE M. McCULLEN</i> | | | | 14. MOTHER'S MAIDEN NAME <i>MARGARET BOWER</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i> | | | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT ADDRESS <i>—</i> | | | | | |
| 18. <i>7625 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory Failure</i> | | | | CAUSE OF DEATH (A) DUE TO <i>Passive Primary Arteritis</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Proneuritis</i> | | | | (B) DUE TO | | | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>—</i> | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>—</i> | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> | | 20A. AUTOPSY? (Yes or No) <i>—</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>—</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i> | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i> | | 21E. INJURY OCCURRED (While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>—</i> | | 21F. HOW DID INJURY OCCUR? <i>—</i> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/31/65</i> 19 to <i>1/31/65</i> 19 that (I) (we) last saw the deceased alive on <i>1/31/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Alonso Gomez</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> <i>Husek</i> | | | | 23B. DATE SIGNED <i>1/31/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>ALONSO GOMEZ</i> | | | | 23D. ADDRESS (Type) <i>Bon Secours Hospital</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/2/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Family Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Randallstown Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Loring Byers</i> | | ADDRESS <i>8728 Liberty Rd. Randallstown Md</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

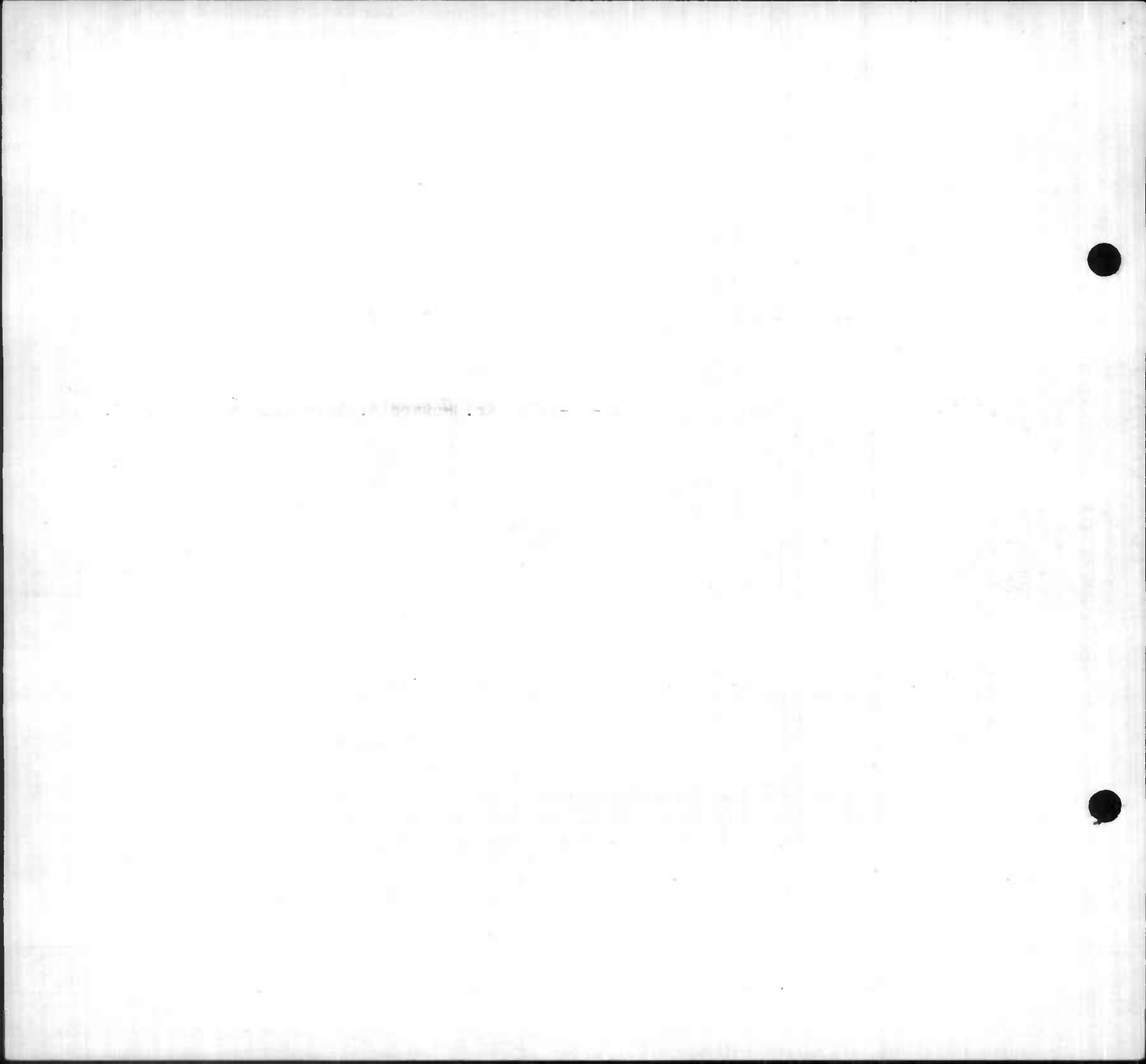
| | | | | | | | |
|---|---------------------|--|--|--|--|---|--|
| 65 1342 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH X | | Registered No. 65 1342 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Richardson, William Weedon</i> | | | | 2. DATE AND HOUR OF DEATH <i>2/1/65 6:10 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital School of Medicine, University of Md.</i> | | | | A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 3300</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>3604 Patterson Ave</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | | 8. DATE OF BIRTH <i>9/12/89</i> | 9. AGE (In years last birthday) <i>75</i> | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Bridge Dept. of Balto. City</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Samuel R. Richardson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Grace Weedon</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>m</i> | | 17. INFORMANT ADDRESS <i>Mrs. E. Elizabeth Kirk 3604 Patterson Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <i>Bilateral Bronchopneumonia</i> (B) <i>Congestive Heart Failure</i> (C) <i>Arteriosclerotic Cardiovascular Disease</i> <i>Suppurative Prostatitis</i> | | <i>11 days</i> <i>11 days</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>1/22/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Benign Prost. Hypertrophy</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/18/65</i> 19 <i>65</i> to <i>2/1/1965</i> that (I) (we) last saw the deceased alive on <i>2/1/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>A. Reo M.D.</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>2/1/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Andres A. Reo M.D.</i> | | | | 23D. ADDRESS <i>University Hospital, U of Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-4-1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Loring Byers Chapel</i> | | ADDRESS <i>Liberty Road</i> | |

James R. Buchanan
of Kentucky

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

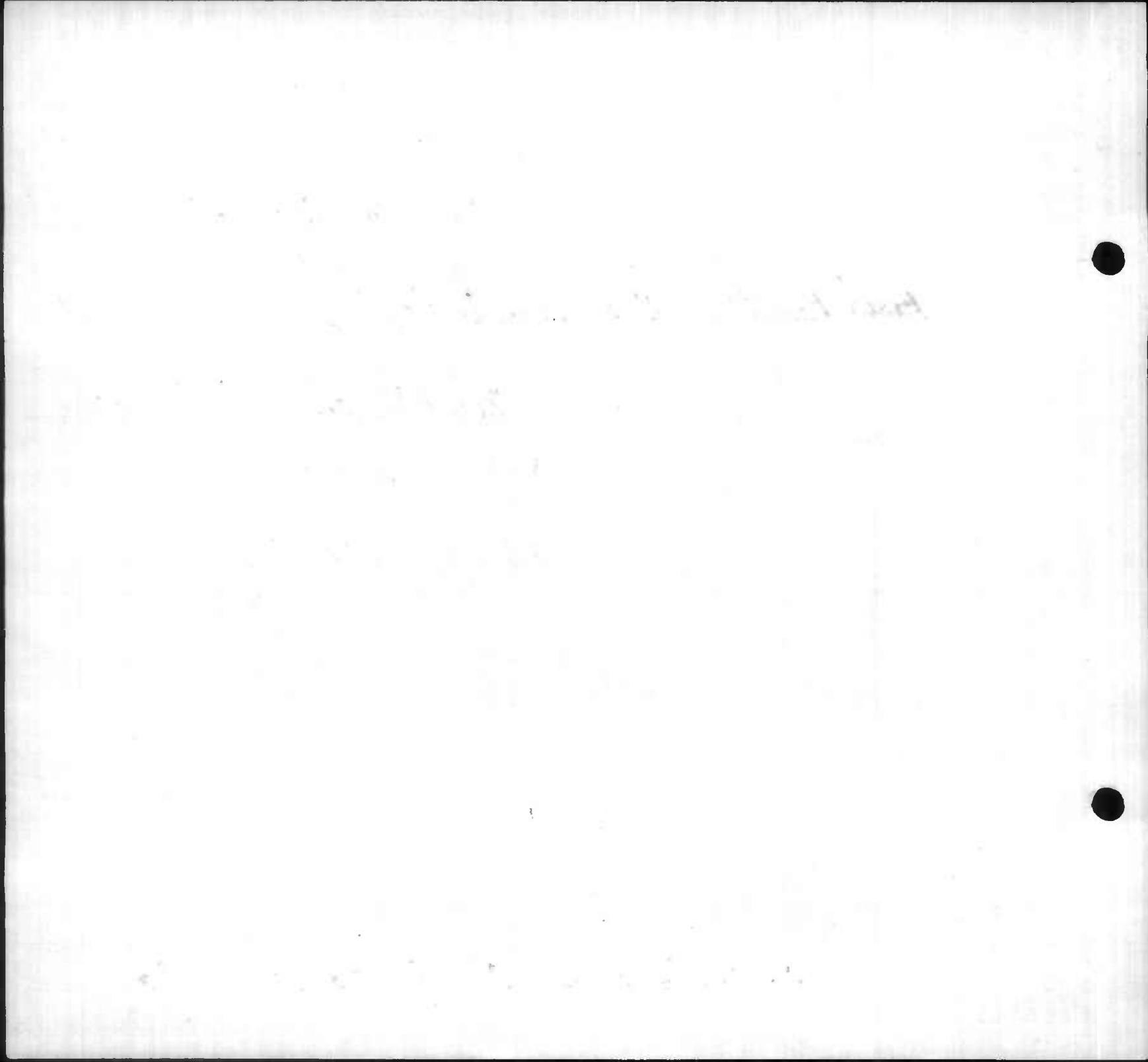
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|---|---|--|--|-----------------------------------|------------------------|--|
| BIRTH NO. 65 1343 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 1343 | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) Peter Vincent Ford | | | | | 2. DATE AND HOUR OF DEATH 2-4-65 1945 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | | | | A. STATE Maryland B. COUNTY 9-05 | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | D. STREET ADDRESS (If rural, give location) 941 Homestead St. 18 | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11/30/79 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired electrician | | | 10B. KIND OF BUSINESS OR INDUSTRY R R | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME John T. Ford | | | 14. MOTHER'S MAIDEN NAME Margaret Robertson | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | |
| 16. SOCIAL SECURITY NO. 218-09-8708 | | | 17. INFORMANT Mr. Howard E. Mitchell | | | ADDRESS 3824 Yolando Road Baltimore, Md. 18 | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease 10 years | | | | | CAUSE OF DEATH (A) DUE TO disease | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal failure 4 days | | | | | (B) DUE TO 4 days | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Perforated Duod. Ulcer 4 days | | | | | (C) DUE TO 4 days | | | | |
| 19A. DATE OF OPERATION 11/31/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Duod Ulcer | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/31 1965 to 2/4 1965 , that (I) (we) last saw the deceased alive on 2/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Howard A. Richter | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/4/65 | | |
| 23C. PHYSICIAN'S NAME (Type) Howard A. Richter | | | | | 23D. ADDRESS Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/8/1965 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Dickner & Sons | | ADDRESS Baltimore, Md. 21217 North & Pa. Avenues | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1344 | |
|--|---------------------|--|--|--|---|
| BIRTH NO. 65 1344 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lillian Campbell | | | |
| 2. DATE AND HOUR OF DEATH 2/4/65 | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY V-43 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Alberta | | | |
| | | D. STREET ADDRESS (If rural, give location) P.F. #1 Box 137 | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-6-25 | 9. AGE (In years last birthday) 40 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beauty Salon Public Shop | | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Robert Tucker | | | 14. MOTHER'S MARRIED NAME Sadie Lomber | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mac Campbell |
| 18. 593 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema | | | CAUSE OF DEATH (A) Uremia (B) Kidney disease ? etiology (C) | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the physician) attended the deceased from 1/19 19 65 to 2/4 19 65 , that (I) last last saw the deceased alive on 2/4 12:15 PM 19 65 and that in (my) opinion opinion death occurred on the date and hour and from the causes stated above. (I) (the physician) (did) (view) view the body after death. | | | | | |
| 23A. SIGNATURE Michael Lesch | | | | 23B. DATE SIGNED 2/4/65 | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL LESCH | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 2/5/65 | | 24C. NAME OF CEMETERY or CREMATORY Hickory Run Church | |
| | | | | 24D. LOCATION (City, town, or county) (State) Rawlings, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Arlington S. Phillips | |
| | | | | ADDRESS 1727 N. Main St. | |



M 345

| | | | |
|--|--|---|--|
| BIRTH NO. <u>64-32305</u> | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) DARRELL MEDLIN | | 2. DATE AND HOUR PRONOUNCED DEAD February 2, 1965 8:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD PROVIDENT HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-01 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1366 N. Fremont Avenue | |
| 5. SEX Male Female | | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single |
| 8. DATE OF BIRTH 11-17-1964 | | 9. AGE (In years last birthday) 2 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME David Medlin | | 14. MOTHER'S MAIDEN NAME Doris Berry | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Doris Berry ADDRESS 1366 N. Fremont Ave. |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitial pneumonitis (A) DUE TO INTERCEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Rickets (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) DUE TO | | | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John E. Adams EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> John E. Adams, M.D. | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2-5-65 | |
| 23C. NAME OF CEMETERY or CREMATORY mt. Calvary | | 23D. LOCATION (City, town, or county) (State) Ann Arundel Co. Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 5 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor | |
| 24C. FUNERAL DIRECTOR William A. Phillips | | 24D. ADDRESS 1727 N. Market St. | |

Letter from Med. Co.
4-20-65 KMH.

W 4361

65 1346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1346

| | | | | | |
|--|--|--|------------------------------|---|-----------------------------|
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Lena Abbott Walter | | Jan. 30, 1965 7:30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HDSPITAL DR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| House of Pines, Belvedere Belvedere Ave., 15, Md. | | | | Md. Balto. Co. Balto | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Balto., 7 | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 8400 Liberty Rd. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| female | white | married | Jan. 24, 1885 | 80yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| housewife | | none | | Birmingham, Alabama | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Dixon W. Abbott | | | USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| no | | | 0 | | |
| 17. INFORMANT | | | ADDRESS | | |
| Daniel C. Walter, 8400 Liberty Rd., Balto. 7 | | | Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 443X + E902.0 | | Cerebral Vascular Accident | | 1 day | |
| ANTECEDENT CAUSES | | 2 PREVIOUS CVA EPISODES | | 10 YEARS + | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Hypertensive C.V. disease and | | 12 YEARS AGO | |
| II | | Int. Atherosclerotic Heart and | | 15 YEARS | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Fracture - LEFT, NECK FEMUR | | JAN 14-1965 | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| JAN-14-1965 | FR. LEFT FEMUR | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | HOME | 8400 LIBERTY RD - BALTO 7 - MD | | | |
| 21D. TIME OF INJURY (APPRX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| JAN 14 65 7AM | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | PT. FELL FROM BED | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 15 1900 to JAN. 30 1965, that (I) (we) last saw the deceased alive on JAN-30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Thomas E. Wheeler | | | | 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Thomas Wheeler, M. D. | | | | M.D. 3601 Clifmar Rd., Balto., 7, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| burial | Feb. 2, 1965 | Lakeview Memorial | | Carroll Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 8 1965 | | Robert E. Taylor, M.D. | | Md. 21133 ADDRESS | |
| Loring Byers, 8728 Liberty Rd., Randallstown | | | | | |

M.E. CASE
 Return To: John Boyle
 FUNERAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

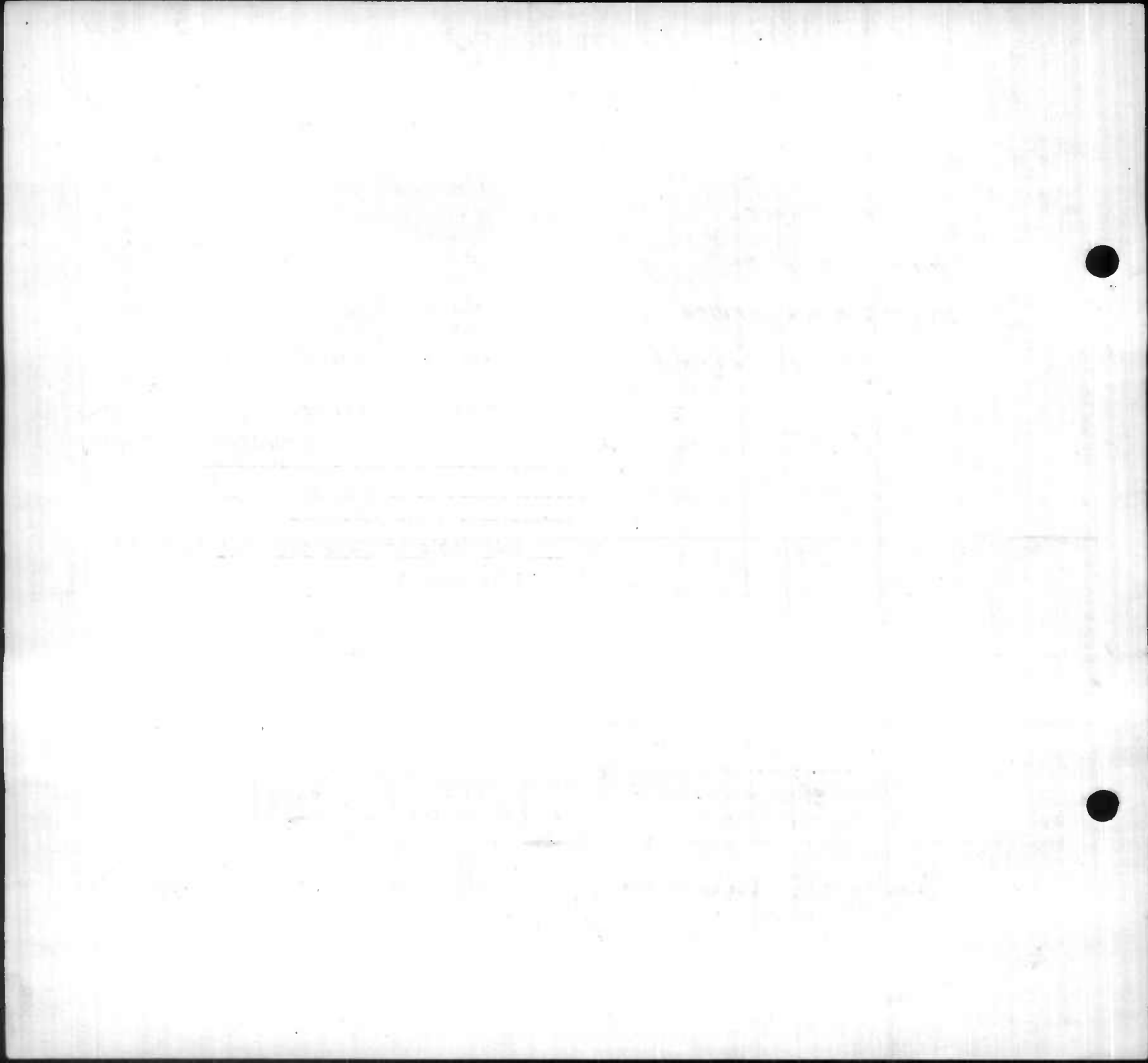
THE UNIVERSITY OF CHICAGO

LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

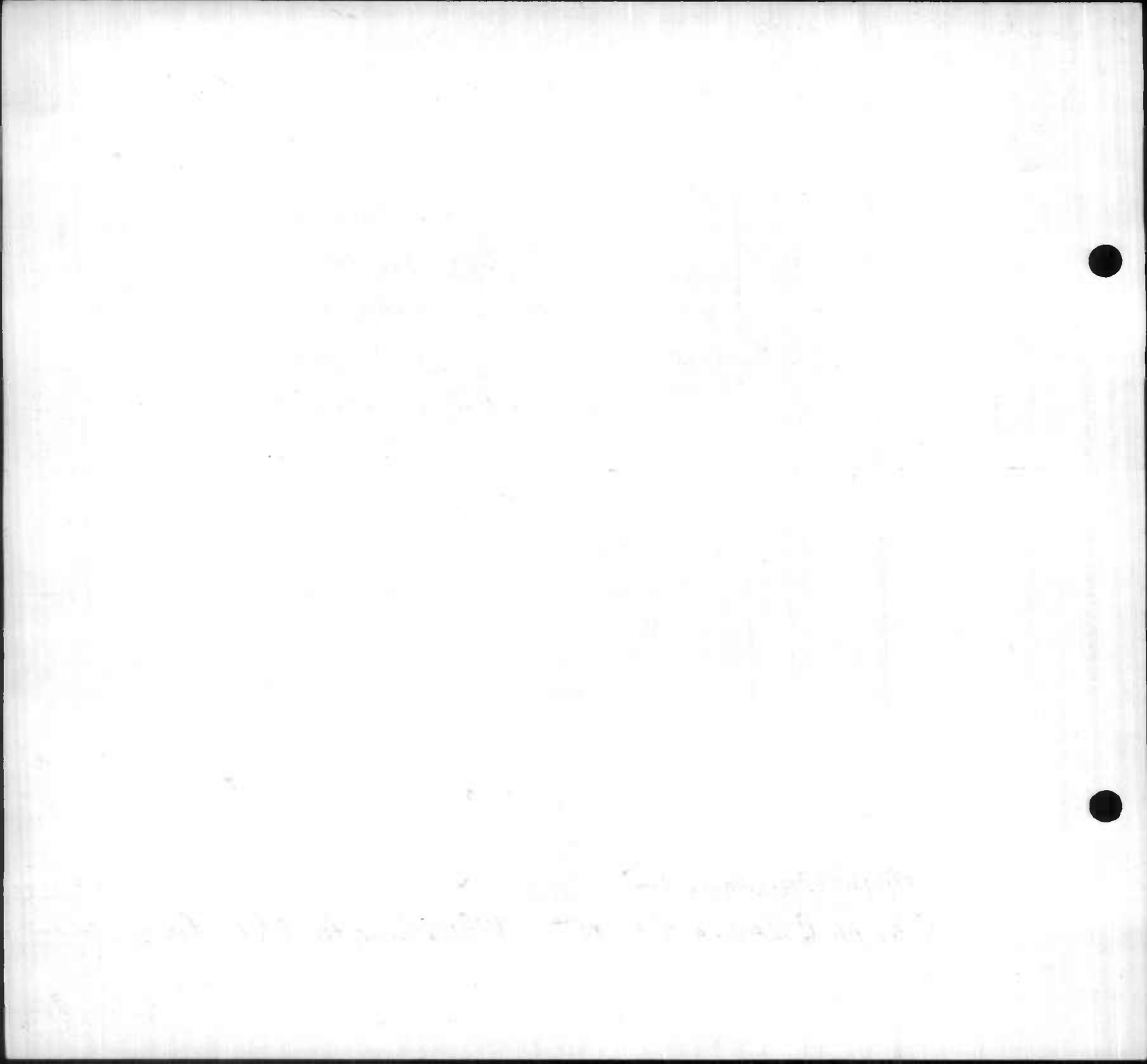
| BIRTH NO. 65 1347 | | | | CITY OF BALTIMORE | | REGISTERED NO. 65 1347 | |
|---|-----------------------------|--|---|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) FRANCIS XAVIER Seibold | | | | 2. DATE AND HOUR OF DEATH 1-30-65 11 50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY Balt | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON | | D. STREET ADDRESS (If rural, give location) 114 W. JOPPA ROAD | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-20-13 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACT ADMINISTRATOR | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charles A. Seibold | | | 14. MOTHER'S MAIDEN NAME Helen Gertrude FAIRLEY | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 6-746-0810 | | 17. INFORMANT ADDRESS chart - Union Memorial Hospital | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH Bilateral bronchopneumonia and coliform septicemia | | INTERVAL BETWEEN ONSET AND DEATH just | |
| | | | | (A) DUE TO calculi and liver abscess | | | |
| | | | | (B) DUE TO Cholelithiasis and hepatolithiasis with | | | |
| | | | | (C) DUE TO liver abscess | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Organizing subdural hematoma <i>just</i> | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>just</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) parking lot <i>just</i> | | 21C. WHERE DID INJURY OCCUR? Bendix Radio Corp. Joppa Rd. Towson <i>just</i> | | | |
| 21D. TIME OF INJURY (APPROX.) Jan. 11, 1965 | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell striking head <i>just</i> | | | |
| 22. I certify that (this hospital) attended the deceased from 1-21-65 to 1-30-65 , that (we) last saw the deceased alive on 1-30-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lawrence J. Lieberman | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) LAWRENCE J. LIEBERMAN | | | | 23D. ADDRESS UNION MEMORIAL HOSP. | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE Feb. 2, 1965 | | 24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.A. | | 25C. FUNERAL DIRECTOR Frank A. Newell, Baltimore | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2. 2201

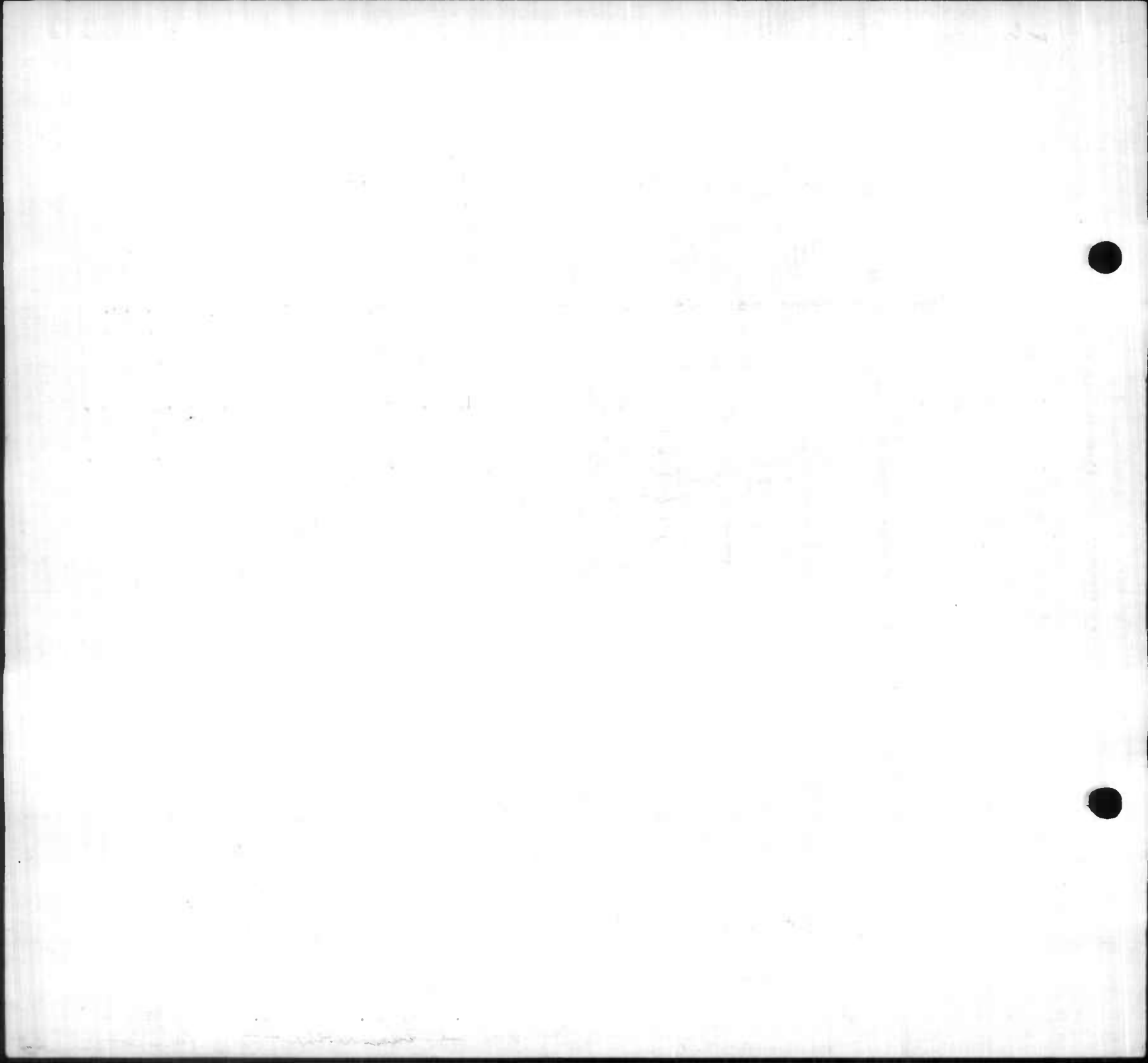
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1348 | |
|--|-------------------------|---|--|--|-----------------------------|---|------------------------------|
| BIRTH NO. 65 1348 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Vincent Lukos | | 2. DATE AND HOUR OF DEATH February 3, 1965 11 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 20-03 | |
| 2046 Hollins St. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2046 Hollins St. | | | |
| 5. SEX MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH DEC. 15, 1886 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-03-5608 | | 17. INFORMANT ADDRESS Anna Lukos 2046 Hollins St. | | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Coronary Thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH 1 da | | | |
| II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Arteriosclerosis Cardiovascular Disease | | | |
| | | | | (B) DUE TO 10 yr | | | |
| | | | | (C) _____ | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-8-55 19 65 to 2/3 19 65 , that (I) (we) last saw the deceased alive on 2/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph G. Laukaitis MD | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/5/1965 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS MD | | | | 23D. ADDRESS 679 Washington Blvd Baltimore 30nd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-5-65 | | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab Funeral Home Francis W. Miller 2101 Paulina Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 1349</u> | |
|--|---------------------|---|--|--|--|---|---|
| BIRTH NO. <u>65 1349</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>GEORGE DELKER</u> | | 2. DATE AND HOUR OF DEATH <u>2/4/65</u> <u>12⁰⁰ Noon</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>9-05</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> 21218 D. STREET ADDRESS (If rural, give location) <u>941 GORSUCH AVE.</u> | | | |
| 5. SEX <u>H</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>8/9/79</u> | 9. AGE (In years last birthday) <u>85</u> | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Elevator Oper</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Sieff Piano Co</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>WILLIAM DELKER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LAURA GIRKY</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>218-42-4878</u> | | 17. INFORMANT <u>John J. Delker, 941 Gorsuch Ave., Baltimore</u> | | | |
| 18. <u>572.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Overheated</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic lung disease</u> <u>Cor Pulmonale</u> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Long standing</u> | |
| <div style="display: flex; justify-content: space-between;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">MEDICAL CERTIFICATION</div> <div> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> </div> | | | | | | | |
| 19A. DATE OF OPERATION <u>2/4/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ventilator abdomen</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/25/65</u> 19 to <u>2/4/65</u> 19, that <u>we</u> last saw the deceased alive on <u>2/4/65</u> 19 and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>H.D. Agnew</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>2/4/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>H.D. AGNEW</u> | | | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-6-65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 8 1965</u> | | 25B. NAME of REGISTRAR <u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul Street, 21202</u> | | ADDRESS | |



65 1350

BALTIMORE CITY HEALTH DEPARTMENT

65 1350

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUSSELL LEZENDERRY (Levenberry)

2. DATE AND HOUR PRONOUNCED DEAD

January 30, 1965

8:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1103 Pennsylvania Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1/1/1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-227535

17. INFORMANT

ADDRESS

Mr. Edward Riley

1103 Pennsylvania Ave

18.

443X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-6-65

23C. NAME OF CEMETERY or CREMATORY

Mount Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A.A. County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

The Morton & Dyett Funeral Homes, Inc.
916 Pennsylvania Avenue
Baltimore, Maryland 21201

ADDRESS

MEDICAL RECORD

DATE: 10/10/1910

NAME: J. H. HARRIS

AGE: 35

SEX: M

ETHNICITY: W

RELIGION: M

MARRIAGE: M

CHILDREN: 2

EDUCATION: H

OCCUPATION: M

RESIDENCE: M

DATE OF BIRTH: M

PLACE OF BIRTH: M

DATE OF DEATH: M

PLACE OF DEATH: M

CAUSE OF DEATH: M

DATE OF BURIAL: M

PLACE OF BURIAL: M

DATE OF INTERMENT: M

PLACE OF INTERMENT: M

DATE OF CREMATION: M

PLACE OF CREMATION: M

DATE OF REINTERMENT: M

PLACE OF REINTERMENT: M

DATE OF RECREMATION: M

PLACE OF RECREMATION: M

DATE OF REINTERMENT: M

PLACE OF REINTERMENT: M

DATE OF RECREMATION: M

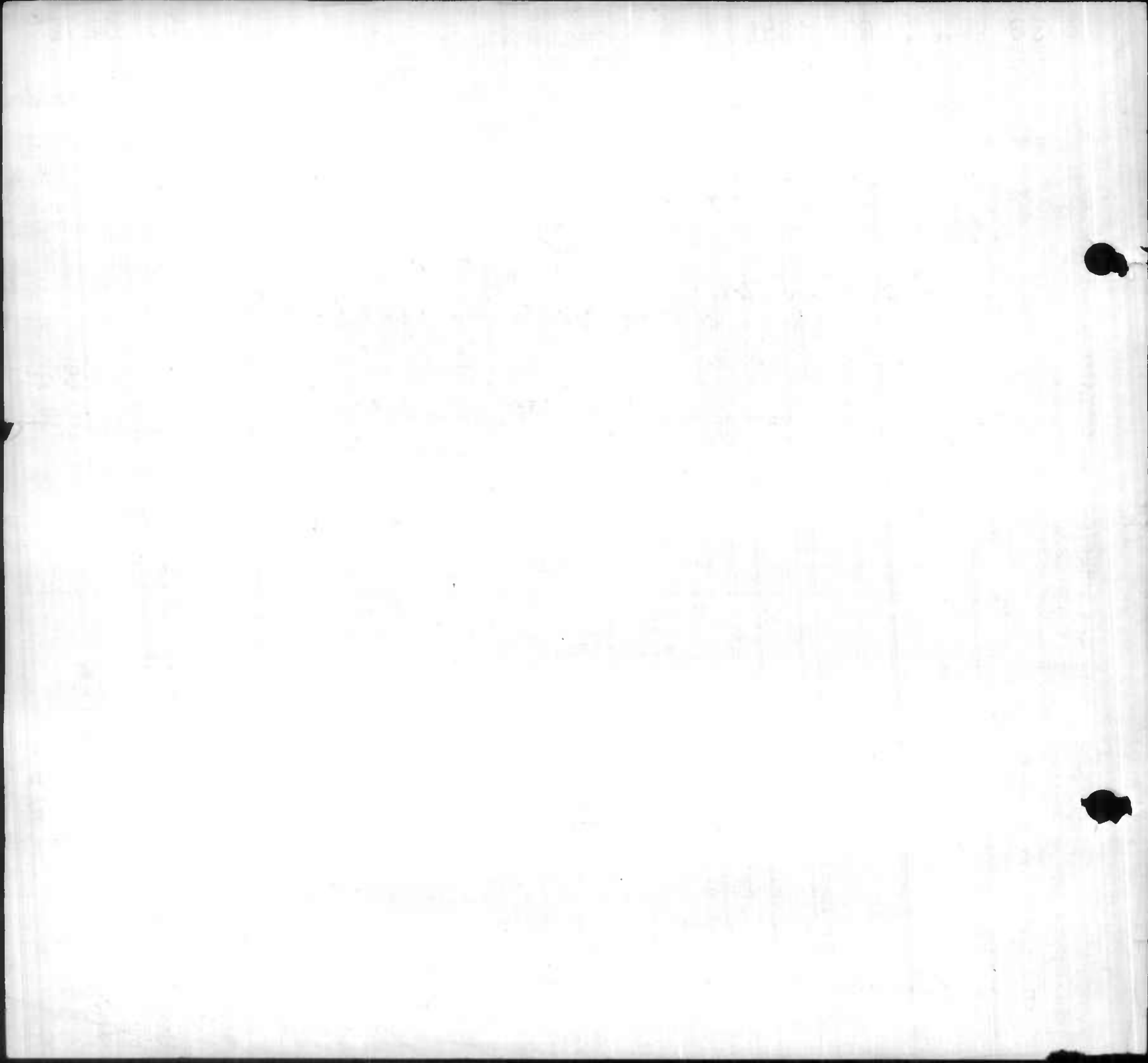
PLACE OF RECREMATION: M

DATE OF REINTERMENT: M

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1351 | | | | CITY HEALTH DEPARTMENT | | Registered No. 65 1351 | |
|---|---------------------|--|-----------------------------------|---|--|---|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Raymond, Alice</i> | | | | 2. DATE AND HOUR OF DEATH <i>3/4/65 12⁰⁰ NOON P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Balt.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>5129 Chalgrave Ave.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <i>2/4/06</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work) <i>Textile Decorator</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Union Wallpaper Co</i> | | 11. BIRTHPLACE (State or foreign country) <i>Vandergrift, Pa.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Preston Aiken</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Zoe Tanager</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>217-26-5330</i> | | 17. INFORMANT <i>John D. Raymond 5129 Chalgrave Ave</i> | |
| 18. <i>420.1 + 2604</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO <i>Myocardial Infarction</i> (B) DUE TO <i>H.A.S.C.V.D.</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>14 hours</i> <i>approx 5 years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i> <i>Several years</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/30 1964</i> to <i>3/4 1965</i> , that (I) (we) last saw the deceased alive on <i>2/4 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Donald Rice</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | 23B. DATE SIGNED <i>2/4/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Donald Rice</i> | | | | 23D. ADDRESS M.D. <i>Sinai Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-6-1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Bethesda Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Spring Byers</i> | | ADDRESS <i>8728 Liberty Road, Randallstown, Md.</i> | |



V-543

65 1352

BALTIMORE CITY HEALTH DEPARTMENT

65 1352

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|---|---|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM VAN LUIT | | | | 2. DATE AND HOUR PRONOUNCED DEAD February 6, 1965 2:25 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Joseph Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4623 Kavon Avenue | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 10, 1929 | 9. AGE (In years last birthday) 35 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Brewery | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Van Luit | | | | 14. MOTHER'S MAIDEN NAME Don't know | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 | | 16. SOCIAL SECURITY NO. 276-20-4276 | | 17. INFORMANT ADDRESS Mrs. Mary Van Luit 4623 Kavon Ave. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Occlusive coronary arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2-7-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker M.D. DATE SIGNED 2-7-65 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2/10/65 | | 23C. NAME of CEMETERY or CREMATORY Gardens of Faith | | 23D. LOCATION (City, town, or county) (State) Overlea, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road. | | | |

WILLIAM FORBES

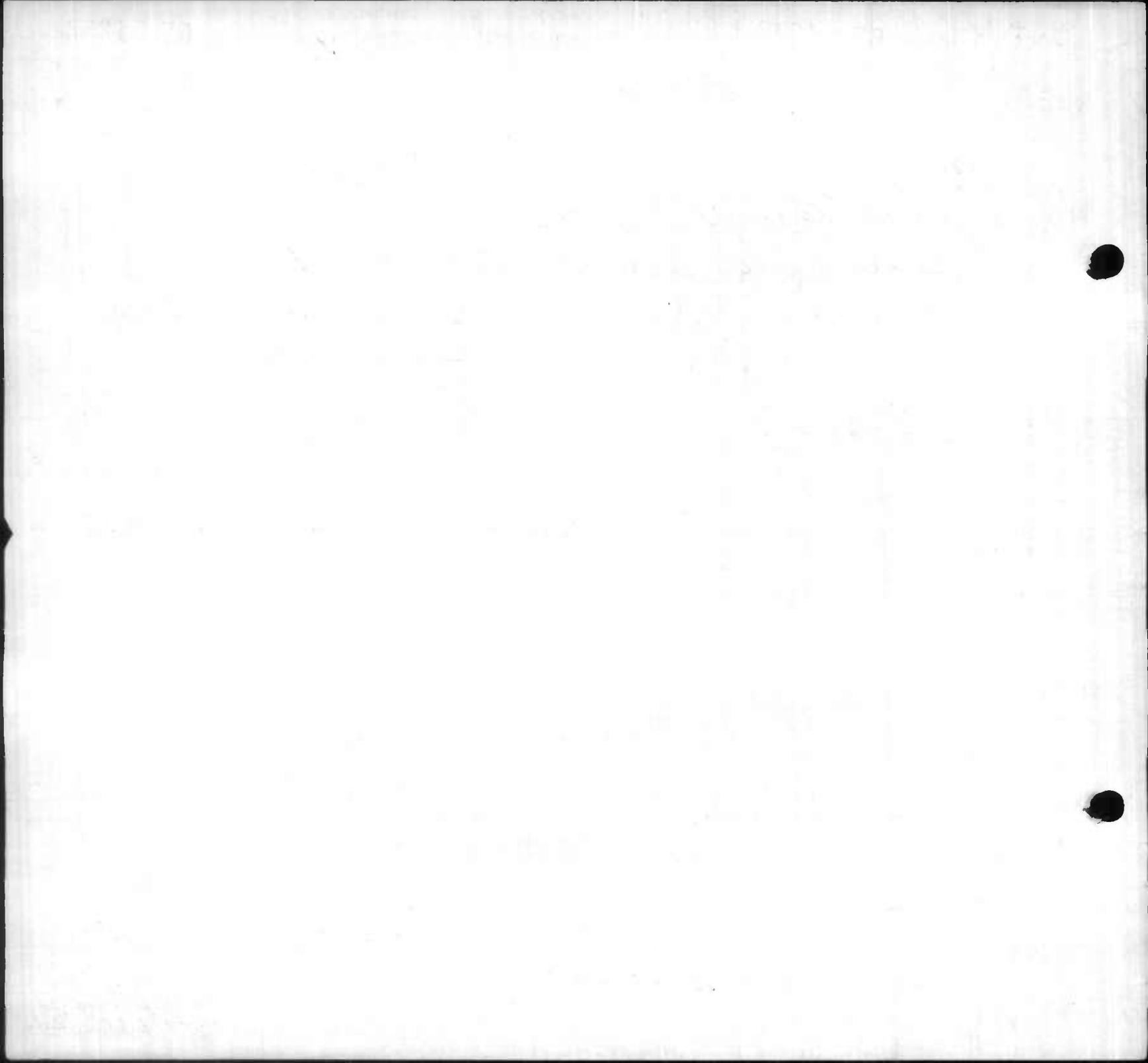
SON OF WILLIAM FORBES

William Forbes

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

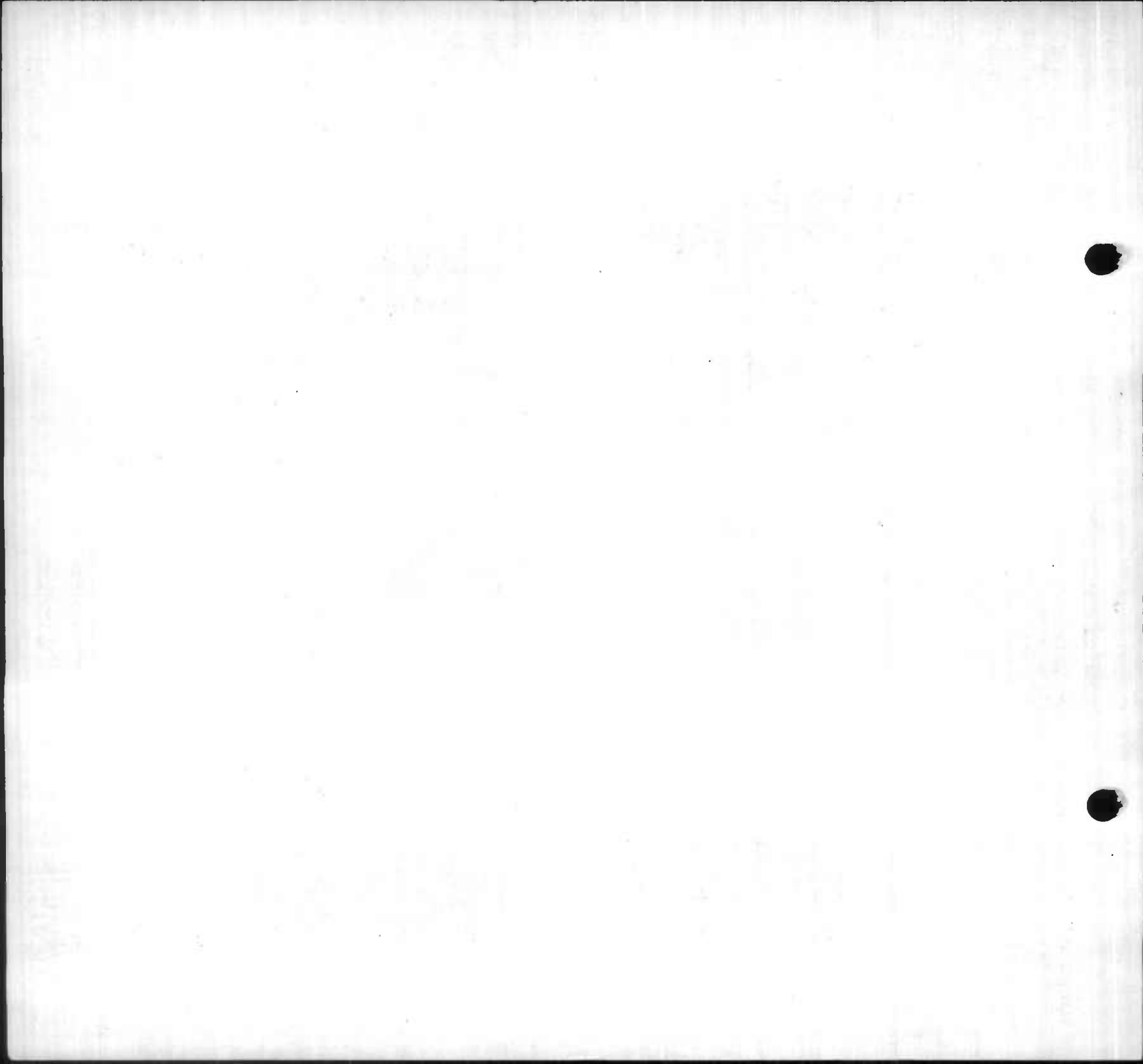
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1353 | | | | |
| BIRTH NO. 65 1353 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Joy, Alvin</i> | | | | | 2. DATE AND HOUR OF DEATH <i>2/4/65 11:35 AM</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i> | | | | | A. STATE <i>Maryland</i> | | | | |
| | | | | | B. COUNTY <i>Calvert</i> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Olivet</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>5400</i> | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>3-27-83</i> | 9. AGE (In years last birthday) <i>84 yrs</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>William F. Coster</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Evelyn Dotson Davis Ann ?</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>No</i> | | 17. INFORMANT ADDRESS <i>Mrs Bessie Joy - Olivet, Md</i> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | | |
| | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>No</i> | | | | | (A) <i>Arteriosclerotic Cardiovascular disease</i> | | | | |
| | | | | | (B) <i>Mesenteric Vascular Occlusion</i> <i>4 days</i> | | | | |
| | | | | | (C) _____ | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i> | | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/3</i> 19 <i>65</i> to <i>2/4</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>2/4</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Howard A. Richter</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>2/4/65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Howard A. Richter</i> | | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Feb 7 1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Oliver Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Oliver - Calvert Co., Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | | 25C. FUNERAL DIRECTOR ADDRESS <i>Mt. Airy, Md. 34</i> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

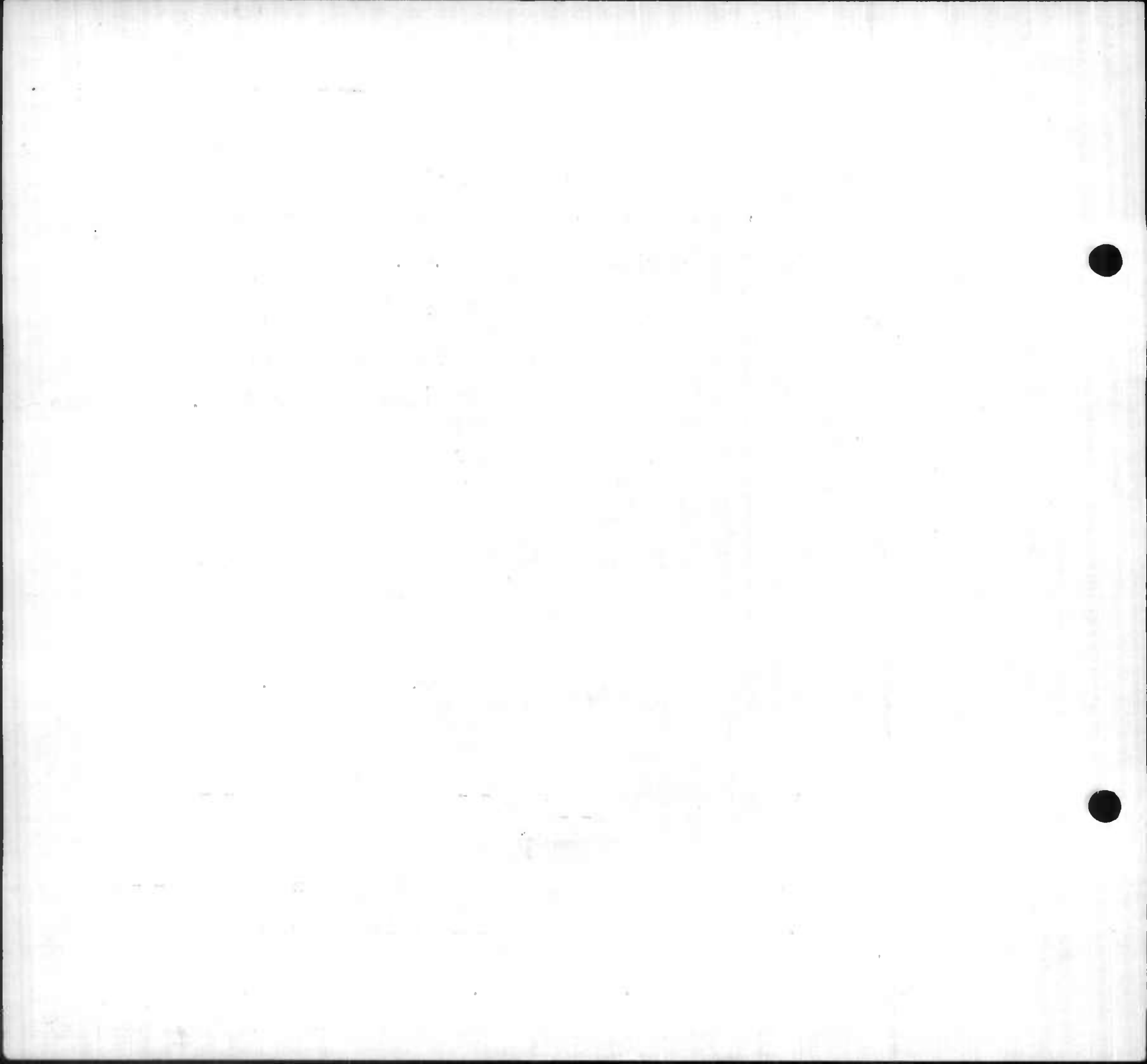
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1354 | |
|--|--|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1354 | | | | | |
| M.E. CASE NO. 65 1354 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Lacher Annie E. | | 2. DATE AND HOUR OF DEATH 2/5/65 6:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital | | A. STATE Maryland B. COUNTY 23-03 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 30 | | D. STREET ADDRESS (If rural, give location) 1814 Light Street | | | |
| 5. SEX A | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 10/29/1895 | 9. AGE (In years last birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME James Connolly | | 14. MOTHER'S MAIDEN NAME Geneva Browning | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Family - Same | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 7 days. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6:20 PM 2/5 1965 to 19 that (I) (we) last saw the deceased alive on 6:20 PM 2/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Byong Koo Kim M.O. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Byong Koo Kim M.O. | | | | 23D. ADDRESS Franklin Square Hospital | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE 2/9/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR McCully, M.F. | | ADDRESS 130 Fort. Ave. City 30, Md | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1355 | |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 65 1355 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Daisy Reed | | | 2. DATE AND HOUR OF DEATH 2-5-65 9:20a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1410 Presstman Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Sept. 9, 1924 | 9. AGE (In years last birthday) 40 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? | | 10B. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME ? | | | 14. MOTHER'S MAIDEN NAME Catherine Johnson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Sylvester Floyd 1612 W. Laffayette Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 491x I Bronchopneumonia Eclampsia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes. | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-3-65 19 to 2-5-65 19, that (I) (we) last saw the deceased alive on 2-5-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Balbino Tayag, Jr. M.D. | | | | 23B. DATE SIGNED 2-6-65 | |
| 23C. PHYSICIAN'S NAME (Type) Balbino Tayag | | | | 23D. ADDRESS M.D. 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/9/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS George H. Kilmer 1348 N. Calhoun St. | | | |



1
J-525

65 1356

BALTIMORE CITY HEALTH DEPARTMENT

65 1356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|---|-------------------------------------|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) BEATRICE JOHNSON | | | | 2. DATE AND HOUR PRONOUNCED DEAD February 4, 1965 4:58 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2466 Woodbrook Avenue | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12/25/13 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Fla. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Lawrence Smith 2445 Woodbrook Ave | | | |
| 18. 331 X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Cardiovascular Disease. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | (A) Intracerebral Hemorrhage DUE TO | | | |
| | | | | (B) _____ DUE TO | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/4/65 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2/9/65 | | 23C. NAME OF CEMETERY or CREMATORY Baltimore Natl. Cem. | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS George H. Kelen 1318 N. Calhoun St | | | |

VALLEY FORD

ALCOHOLIC BEVERAGES

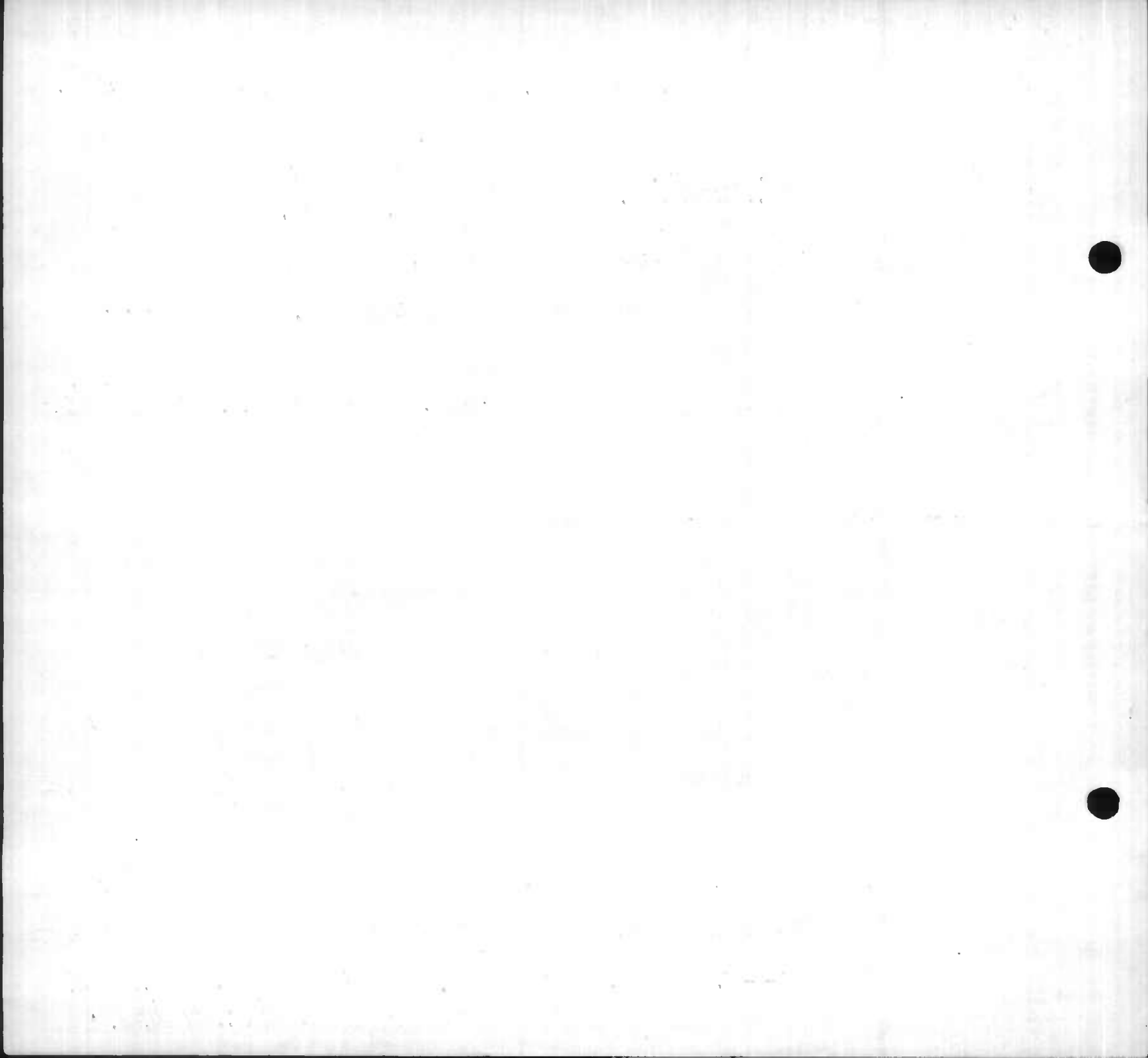
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Class

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|-------------------------------------|--|---|--|--|------------------------------------|--|--|--|--|
| BIRTH NO. 65 1357 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1357 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | | | | | |
| Mary M. Buczkowska. | | | | | February 4, 1965 | | | | | 6:15 P. M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE | | | | | B. COUNTY | | | | | | | | | |
| 824 S. East Ave. Balto., 21224, Md. | | | | | Md. | | | | | 26-11 | | | | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | | | | | | | |
| | | | | | Baltimore # 21224 | | | | | | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | | | | | | | | | | | |
| | | | | | 824 S. East Ave. | | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| Female | | White | | Widowed | | July 24, 1887 | | 77 | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| Retired | | | | House Work | | | | Baltimore, Md. | | | | U.S.A. | | | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| ? Stetz | | | | | Unknown | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | ADDRESS | | | | |
| No | | | | | None | | | | | Anna M. Zegzdryn | | | | | 2594 S.W. 26th Lane Miami, Fla. | | | | |
| 18. 4 22, 1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | | CEREBRO VASCULAR HEMORRHAGE | | | | | 2-1-65 | | | | | | | | | |
| | | | | | DUE TO | | | | | | | | | | | | | | |
| | | | | | (B) ARTERIO SCLEROTIC | | | | | | | | | | | | | | |
| | | | | | DUE TO | | | | | | | | | | | | | | |
| | | | | | (C) C.V. DISEASE | | | | | 1961 | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| II | | | | | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| NONE | | NONE | | NONE | | NONE | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | | | | | | | | | | | |
| NONE | | NONE | | NONE | | NONE | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | |
| NONE | | White <input type="checkbox"/> of White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | NONE | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN 2, 19 1965 Feb 4, 19 1965 that (I) was lost saw the deceased alive on 2-4-65 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED | | | | | | | | | |
| E.A. Schimunek | | | | | | | | | | 2-7-65 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | | | | | | | | | | |
| E.A. SCHIMUNEK M.D. | | | | | 842 S. EAST AVE BALTO. MD 21224 | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION | | (City, town, or county) | | (State) | | | | | | | | | |
| Burial | | 2-8-65 | | St. Stanislaus Cem. | | 6515 Boston St. Balto., 24 Md. | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | | | | | |
| FEB 8 1965 | | | | Robert E. Farber | | | | Charles J. Seiler | | | | 801 S. Conkling St. Balto., 21224, Md. | | | | | | | |



40-34-48
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1358

BIRTH NO. 65 1358

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Charles Weissner

2. DATE AND HOUR OF DEATH

February 6, 1965 11:50 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1312 Broening Highway 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-6-1886

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

AMER. ALLOY CO.

11. BIRTHPLACE (State or foreign country)

Maryland, BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

CHARLES WEISSNER

14. MOTHER'S MAIDEN NAME

MADELINE ?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-10-5776A

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18.

600.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Septicemia
DUE TO

13 Days

(B) Chronic Pyelonephritis
DUE TO

(C) Cerebral Vascular Accident

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Inotify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 19, 1964 to February 6, 1965,
that (I) (we) last saw the deceased alive on February 6, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.O.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

Dr. Robert Cooke

M.O.

23D. ADDRESS

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2-9-65

24C. NAME OF CEMETERY or CREMATORY

SACRED HEART CEM

24D. LOCATION

(City, town, or county)

(State)

7401 GERMAN HILL RD, BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

25B. NAME OF REGISTRAR

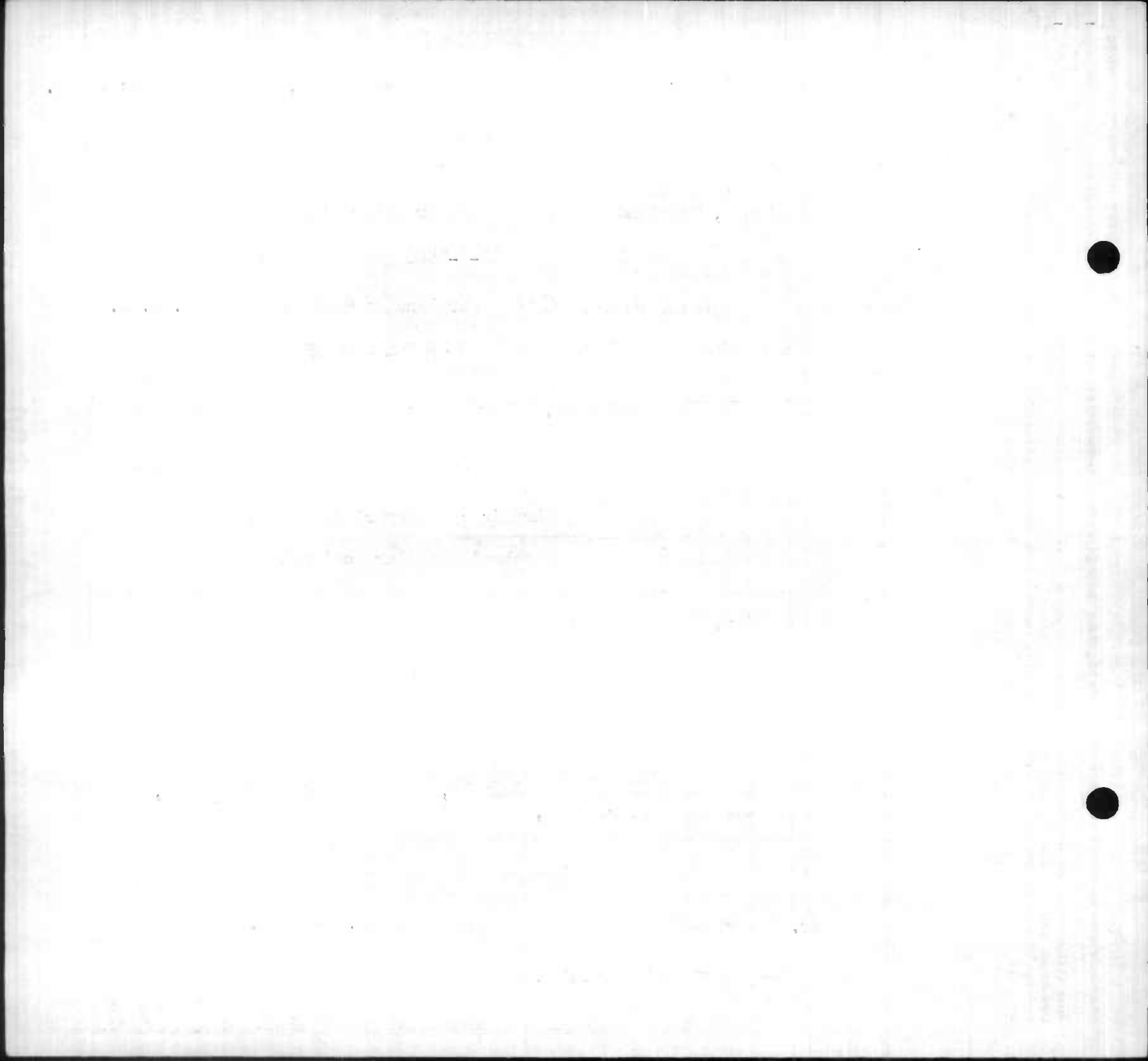
Robert E. Farley, Jr.

25C. FUNERAL DIRECTOR

Charles S. Jellier

ADDRESS

6224 EASTERN AVE,
BALTO., 21224, MD.

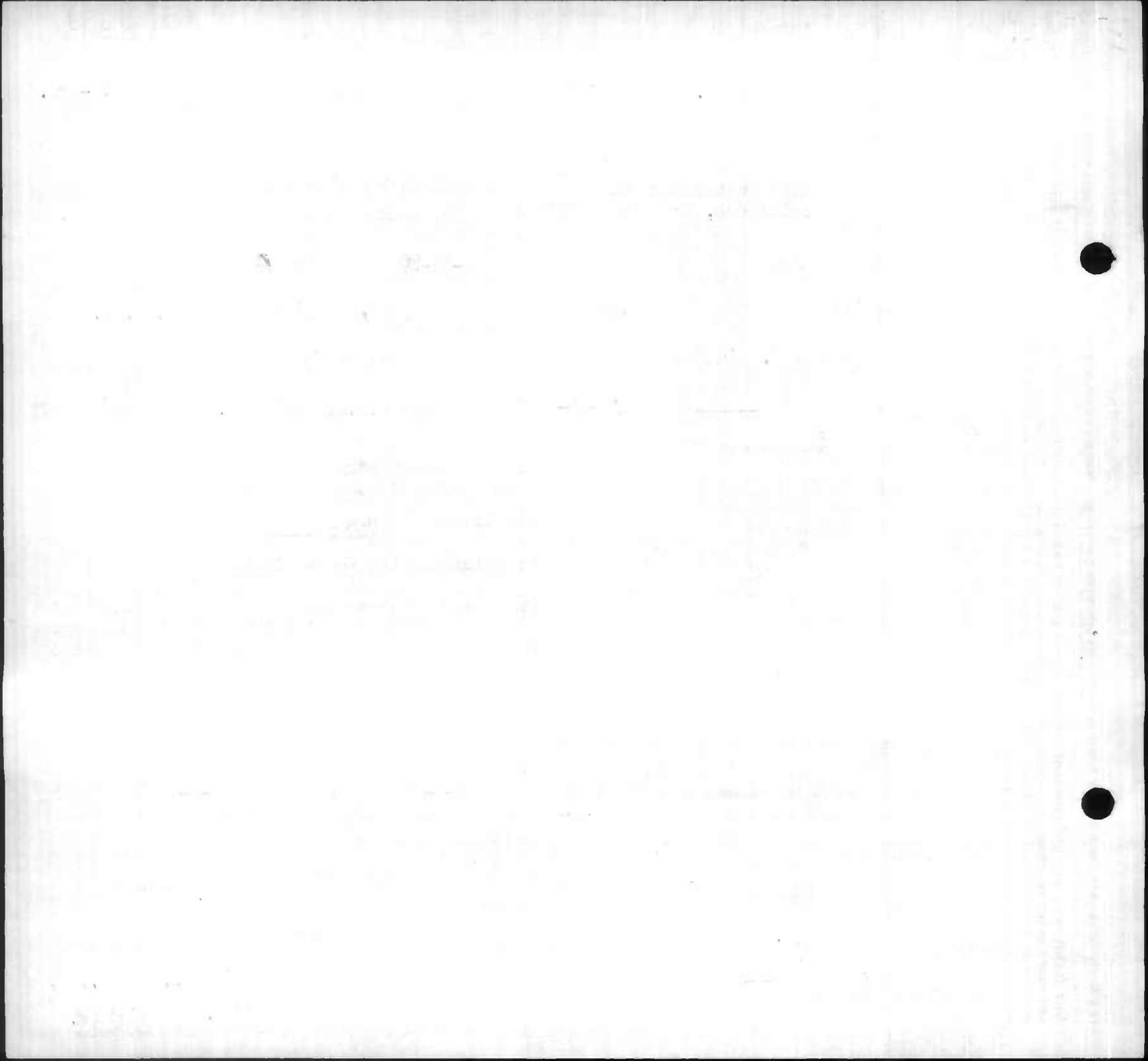


42-27-25 AM 1
F.32

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

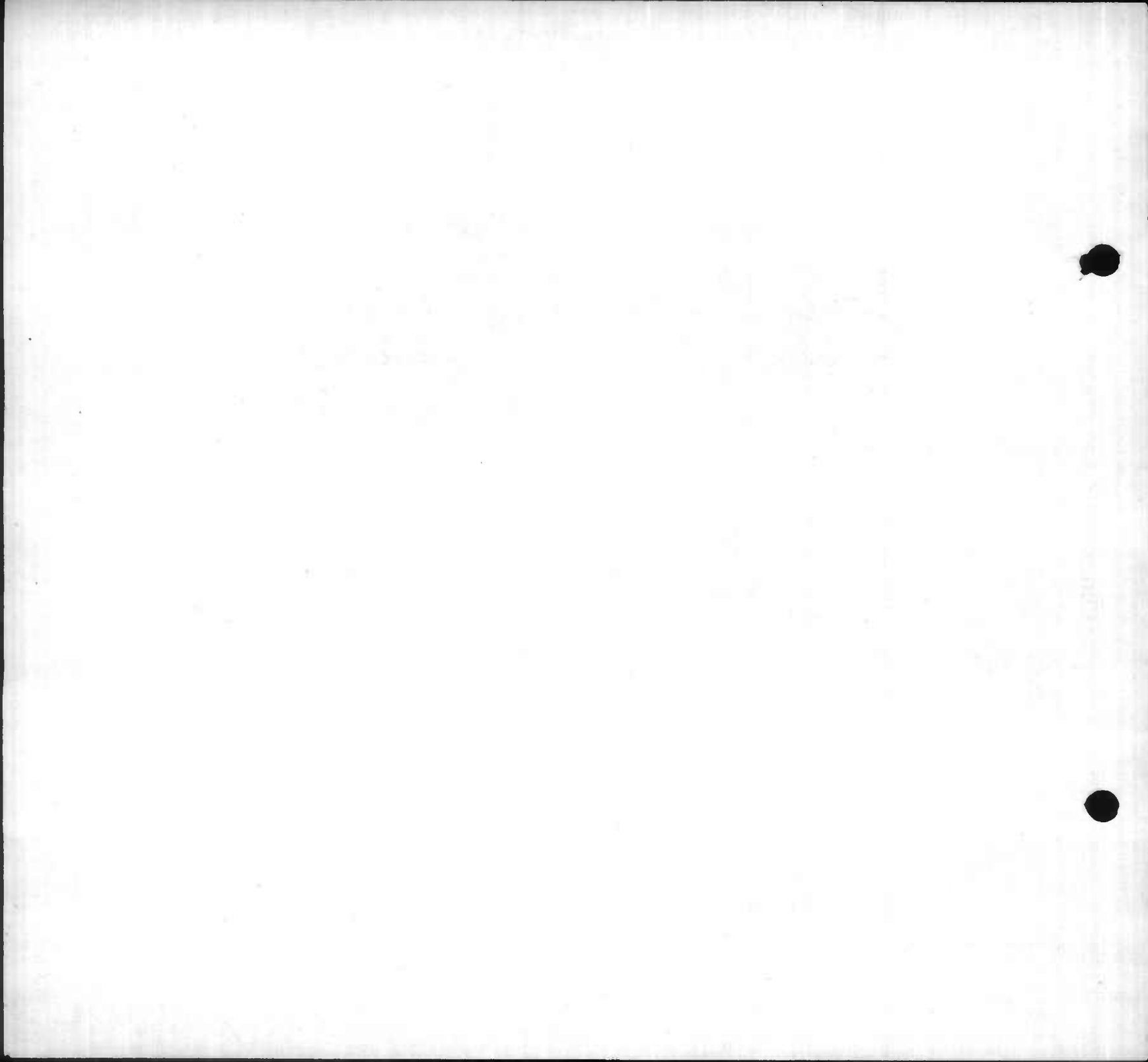
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1359 | |
|--|---------|---|------------------|--|--|
| BIRTH NO. 65 1359 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | | |
| | | Anna M. Fitzpatrick | | | |
| 2. DATE AND HOUR OF DEATH | | 2-4-65 12:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21224 D. STREET ADDRESS (If rural, give location) 1329 South Clinton Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Female | White | Widowed | 2-13-90 | 74 | Retired |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Maryland, Baltimore | | U. S. A. | | Charles H. Winkler | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Margaret Fogler | | No | | 219-32-0837 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | ADDRESS | |
| RECORDS: B.C.H. 4940 Eastern Avenue #21224 | | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) Acute Pulmonary Edema DUE TO Rule Out Pulmonary Embolus | | | |
| | | (B) Congestive Failure DUE TO | | | |
| | | (C) Arteriosclerotic Heart Disease | | | |
| II | | Pulmonary Embolus | | 1 Month Ago | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Cerebral Vascular Accident | | 1 Month Ago | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19C. INTERVAL BETWEEN ONSET AND DEATH | |
| | | No | | 1 Month Ago | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-3-1965 to 2-4-1965, that (I) (we) last saw the deceased alive on 2-4-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dr. Robert Cooke | | | | 2-4-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Robert Cooke | | | | 4940 Eastern Avenue #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-6-65 | | Sacred Heart Cemetery | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 8 1965 | | Robert E. Fisher | | Charles J. Jenkins | |
| | | | | ADDRESS | |
| | | | | 901 S. Conkling St. BALTO., 21224, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

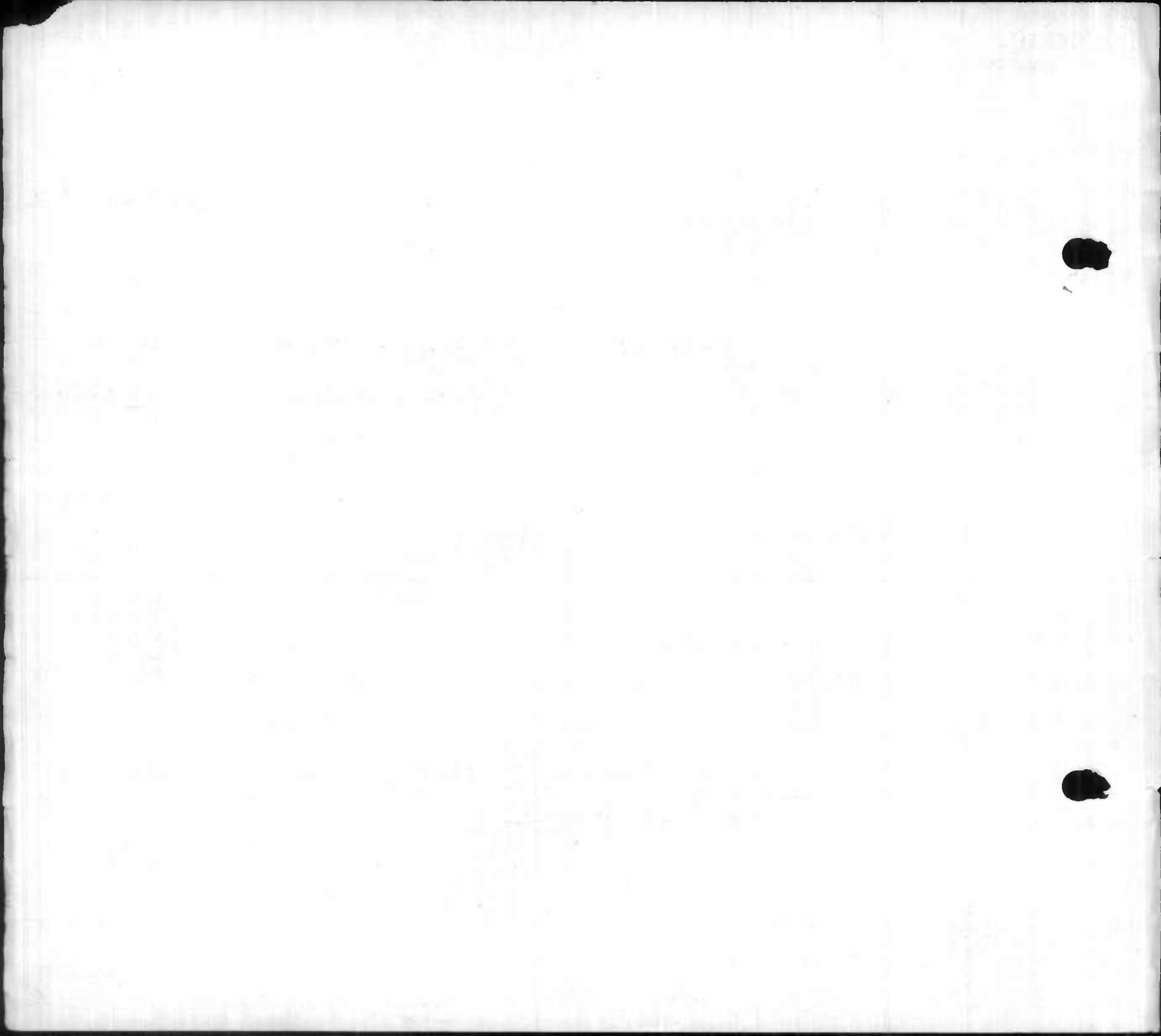
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1360 | |
|---|---------------|--|--------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. 65 1360 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLIAM TRAYNHAM H. | | 2. DATE AND HOUR OF DEATH 2/4/65 4:42 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND JOHNS HOPKINS HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY D. STREET ADDRESS (If rural, give location) 1905 NORTH PAYSON STREET | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9-25-98 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Bethelham Steels. | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Bishop Traynham | | | | 14. MOTHER'S MAIDEN NAME Eva Wade | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 216-10-5207 | | 17. INFORMANT ADDRESS Europa Smith 3809 Oakford Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) METASTATIC CARCINOMA TO BRAIN (B) CARCINOMA of LUNG (C) | | INTERVAL BETWEEN ONSET AND DEATH 13 MO. UNKNOWN | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (4) (this hospital) attended the deceased from Jan 23 19 65 to 4 Feb 19 65 that (4) (we) last saw the deceased alive on 4 February 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lincoln James, Jr. M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Feb 4, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Lincoln James, Jr. M.D. | | | | 23D. ADDRESS 601 N. BROADWAY - BALTIMORE 5 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-7-65 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. Baltimore | | 24D. LOCATION (City, town, or county) (State) MD. | |
| 25A. DATE REC'D BY HEALTH DEPT FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Arlington S. Phillips | | ADDRESS 1727 N. Monroe St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1361 | | CITY OF BALTIMORE | | CERTIFICATE OF DEATH | | Registered No. 65 1361 | |
|--|---------------------|--|--|---|--|--|-----------------------|
| 1. NAME OF DECEASED (Type or Print) GORDON W. FREYMAN | | | | 2. DATE AND HOUR OF DEATH 2/5/65 11:25 PM 11:25 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 1803 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | D. STREET ADDRESS (If rural, give location) 1017 W. BALTIMORE ST. #23 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | | 8. DATE OF BIRTH 3/31/08 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CHARLES FREYMAN | | | | 14. MOTHER'S MAIDEN NAME Lenna S. HATTENBERGER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS EOGLYN JANEUSHECK 300 GREENWAY S.E. | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) VENTRICULAR FIBRILLATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYOCARDIAL INFARCTION ASCVD | | | | CAUSE OF DEATH VENTRICULAR FIBRILLATION ACUTE MYOCARDIAL INFARCTION ASCVD | | INTERVAL BETWEEN ONSET AND DEATH MINUTES HOURS YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHIECTASIS CHRONIC BRONCHITIS GE PULMONALE YEARS | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/5/1965 to 2/5/1965 , that (I) (we) last saw the deceased alive on 2/5/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William S. Byers, M.D. | | | | 23B. DATE SIGNED 2/6/65 | | 23C. PHYSICIAN'S NAME (Type) WILLIAM S. BYERS M.D. | |
| 23D. ADDRESS MERCY HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | |
| 24B. DATE 2-9-65 | | 24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE | | 24D. LOCATION (City, town, or county) (State) ELK RIDGE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Geo. L. Schwartz | | 25D. ADDRESS 614 E. 1st St. Baltimore, Md. | | 25E. NAME OF REGISTRAR Robert E. Farley, M.D. | |



K-640 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1362 | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 65 1362 | |
|--|-------------------------|--|--|--|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <i>Clarence Richard Kerley</i> | | | 2. DATE AND HOUR OF DEATH <i>Feb 3, 1965</i> <i>1:00 P. M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>House In The Pines - Belair</i> <i>5837 - Belair Road Baltimore Md</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>26-01</i> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | D. STREET ADDRESS (If rural, give location) <i>4408 - Raspe Ave</i> | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>Aug - 2, 1903</i> | 9. AGE (In years last birthday) <i>62</i> | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Detective</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Burn's Agency</i> | | 11. BIRTHPLACE (State or foreign country) <i>Asheville - N.C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 13. FATHER'S NAME <i>William D Kerley</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Nancy Robinson</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <i>Mrs. Inez Kerley (wife)</i> <i>4408 - Raspe Ave - Balts 21206</i> | | |
| 18. <i>162.1 I</i> | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Bronchogenic Carcinoma</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from <i>Jan 27, 1965</i> to <i>Feb 3, 1965</i> , that (I) (we) last saw the deceased alive on <i>Feb 2, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Albert D. Dudley</i> | | | 23B. DATE SIGNED <i>2/5/65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REINTERMENT (Specify) <i>Burial</i> | | 24B. DATE <i>2/6/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Garden of Faith</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore - Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR <i>Carl B. Waplington</i> | | | |
| 25D. ADDRESS <i>6306 - Belair Rd, Baltimore - 21206, Md</i> | | | | | |

1861 Aug 20
To the Hon. Secy of the
Treasury
Washington
D.C.

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 1363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 1363

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLES J. GRABER
2. DATE AND HOUR PRONOUNCED DEAD February 4, 1965 8:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD St. Agnes Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville 53-00
D. STREET ADDRESS (If rural, give location) 103 Oakdale Avenue

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married
8. DATE OF BIRTH Oct 13, 1915 9. AGE (in years last birthday) 49
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) power house oper. Calvert Distill
11. BIRTHPLACE (State or foreign country) Catonsville, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William A. Graber Sr.
14. MOTHER'S MAIDEN NAME Reva A. Kahler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II
16. SOCIAL SECURITY NO. 212-05-2085
17. INFORMANT Mrs Caroline B. Graber 103 Oakdale

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Crushed Chest.
DUE TO
INTERVAL BETWEEN ONSET AND DEATH
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Plant
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Joseph E. Seagram & Sons, Inc., Relay 53-00

21D. TIME OF INJURY (APPROX.) February 4 '65 A. m. 21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK []
21F. HOW DID INJURY OCCUR? Caught between Payloader and Freight Car.

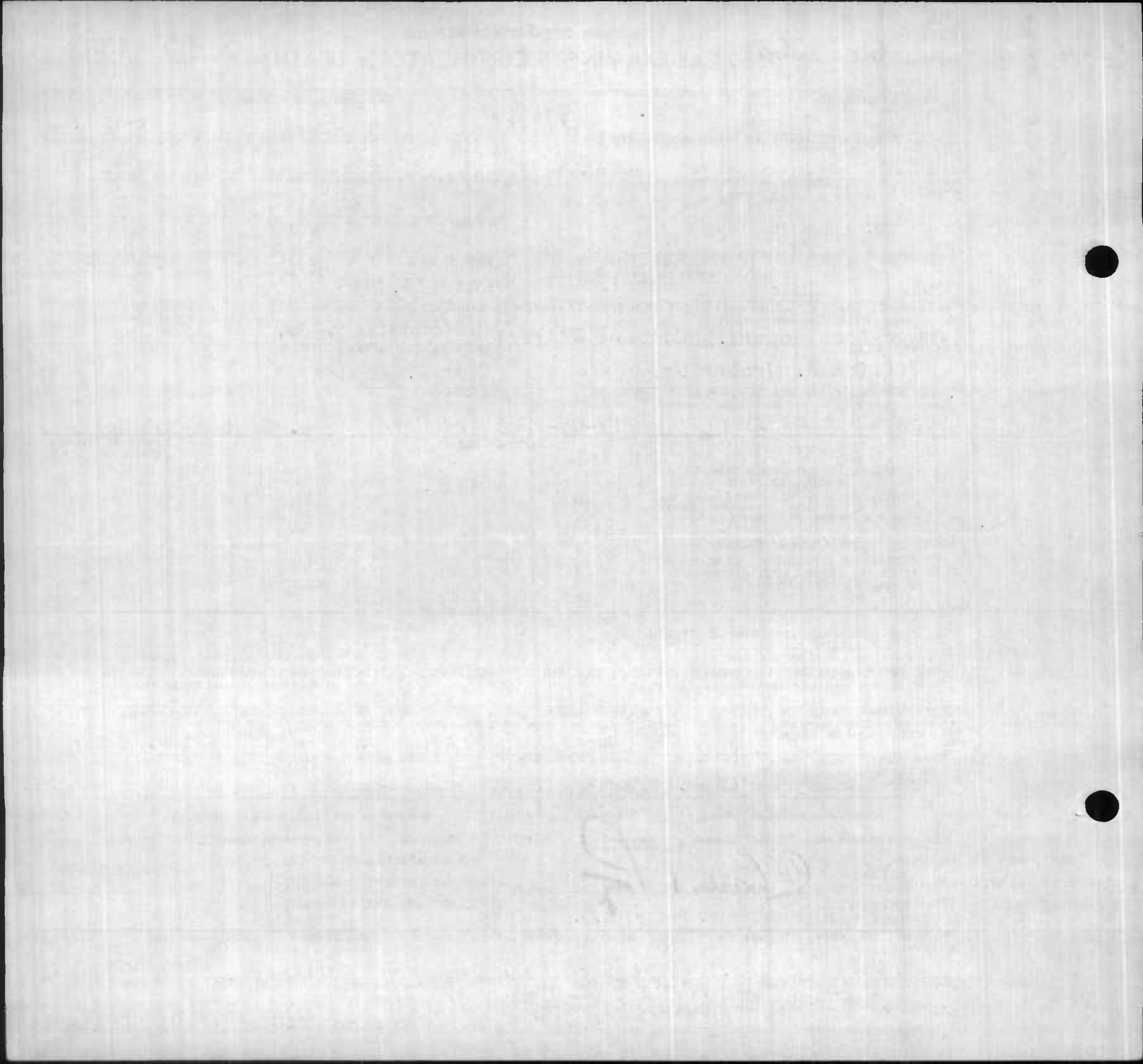
22. I certify that I held on Inquiry [] Inspection [] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [] Accident [X] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE [Signature] CHIEF MEDICAL EXAMINER []
EXAMINER'S NAME (Type) Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER []

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE Feb 8, 1965 23C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 24B. NAME OF REGISTRAR Robert E. Farber, M.D. 24C. FUNERAL DIRECTOR Sterling Funeral Estate 24D. ADDRESS 236 Edmondson Av. Catonsville

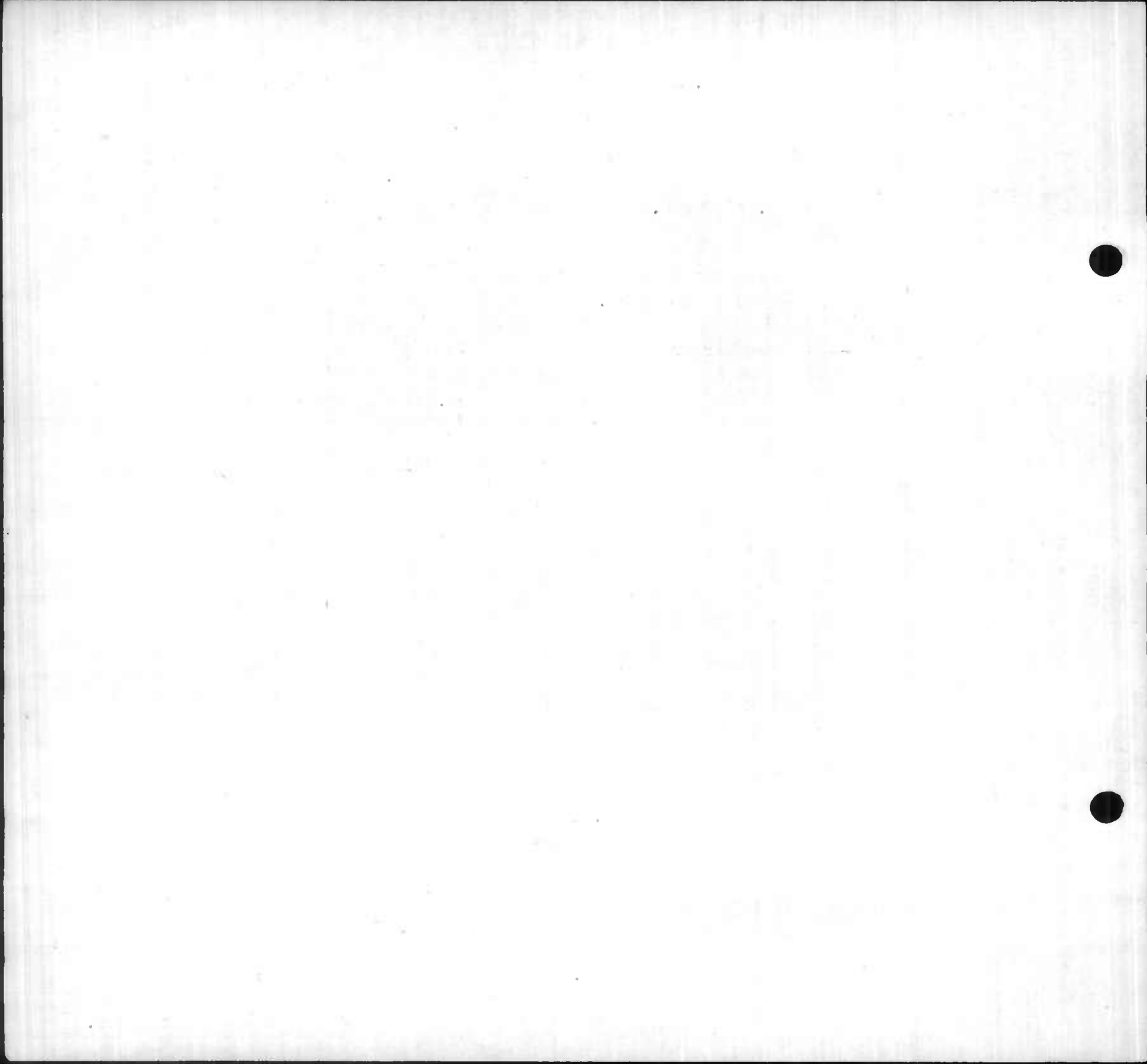
VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-----------|--|-------------------------------|--|--|
| BIRTH NO. 65 1364 | | CERTIFICATE OF DEATH | | 65 1364 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | GEORGE W. ROSENBERGER | | 2/3/65 8PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MD | | B. COUNTY | |
| 806 E. FORT AVE. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTO. | |
| | | D. STREET ADDRESS (If rural, give location) | | 806 E. FORT AVE | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Sep 25, 1883 | 9. AGE (In years last birthday) 81 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) net. Checker | | 10B. KIND OF BUSINESS OR INDUSTRY Longshrm. | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME --- Rosenberg | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Ethel Rosenberg | |
| 18. ADDRESS Same | | 19. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Coronary Occlusion | | Immediate | |
| ANTECEDENT CAUSES | | (A) DUE TO Hypertension arterio sclerotic | | 10 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO heart disease | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 27, 1963 to Feb. 3, 1965 | | that (I) (we) lost saw the deceased alive on Feb. 1, 1965 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Harry Deibel | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Feb 5, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Harry Deibel | | 23D. ADDRESS M.D. 1226 S. Hanover Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/6/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Pk. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR McCully Funeral Home | | ADDRESS 130 E. Fort Ave. | | | |



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65 1365

BALTIMORE CITY HEALTH DEPARTMENT

65 1365

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT C. LONG

2. DATE AND HOUR PRONOUNCED DEAD

February 3, 1965 4:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

529 N. Charles Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

529 N. Charles Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Aug. 9, 1920

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

auto mechanic for Brockway Truck Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Carroll Co., Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles W. Long

14. MOTHER'S MAIDEN NAME

E. Belle Tawney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War II

16. SOCIAL
SECURITY NO.

218-09-3883

17. INFORMANT

Mrs. Lillian T. Long

ADDRESS

529 N. Charles St.
Baltimore 1, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/4/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

2/8/65

23C. NAME of CEMETERY or CREMATORY

Leister's Cemetery

23D. LOCATION

(City, town, or county)

(State)

Westminster RD 4, Carroll, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 8

1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

J. E. Myers & Westminster, Md.

VALLEY FOUNGIE

RAC CONTINUT

USA

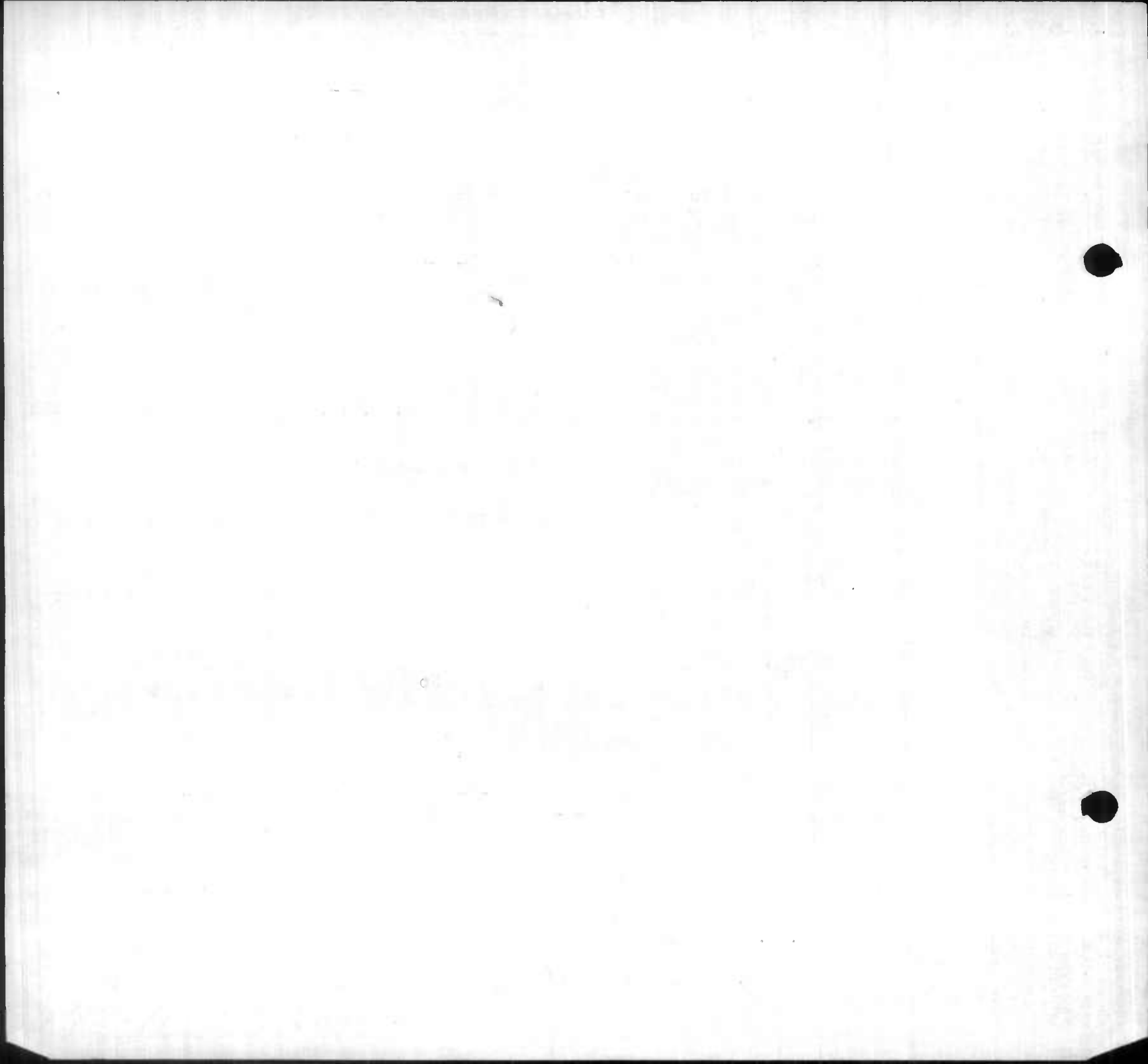
Chas

42-76-06 AM 15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------|--|---|
| BIRTH NO. 65 1366 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1366 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Robert Johnson | | 2-2-65 8:10 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 206 Ballou Court | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-26-97 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Farmville Va | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224 | |
| 18. 609X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Gram Negative Sepsis DUE TO (B) Chronic Urinary Tract Infection DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 Day 8 Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-2-19 65 to 2-2-19 65, that (I) (we) last saw the deceased alive on 2-2-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. M. Schuster | | | | 23B. DATE SIGNED 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. M. Schuster | | | | 23D. ADDRESS 4940 Eastern Avenue #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 2/11/65 | | 24C. NAME OF CEMETERY OR CREMATORY my auburn cemetery Baltimore md | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| | | 25C. FUNERAL DIRECTOR A. H. Heston | | 25D. ADDRESS 918 Druid Hill av | |



32-23-21 AM 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1367

BIRTH NO. 65 1367

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Everett

2. DATE AND HOUR OF DEATH

2-4-65

8:05 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2305 Calverton Heights Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married Sep

8. DATE OF BIRTH

9-23-09

9. AGE (in years
last birthday)

55

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Ander Everett

14. MOTHER'S MAIDEN NAME

Lucy Cole

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B. C. H. 4940 Eastern Avenue #21224

18.

260X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary Embolism
DUE TOINTERVAL BETWEEN
ONSET AND DEATH
Immediately at
8:05 a.m. 2-4-65

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Melitis and Gangrene of feet

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-8 19 64 to 2-4- 19 65
that (I) (we) last saw the deceased alive on 2-4- 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

2-4-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Richard Lane

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Feb. 9, 1965

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

(City, town, or county)

Balto.

Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

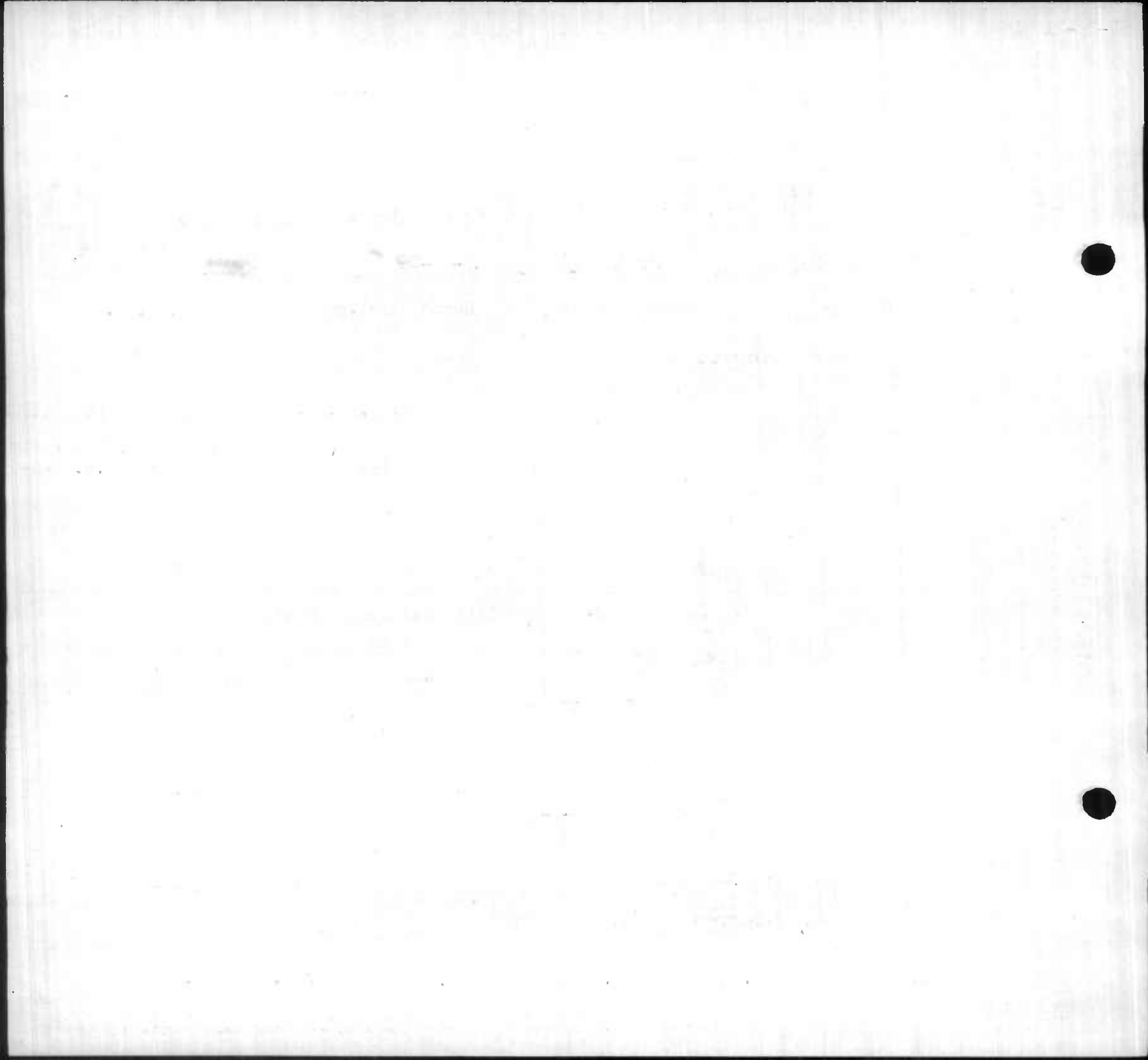
25C. FUNERAL DIRECTOR

Williams Funeral Home 39 N. Schwab

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

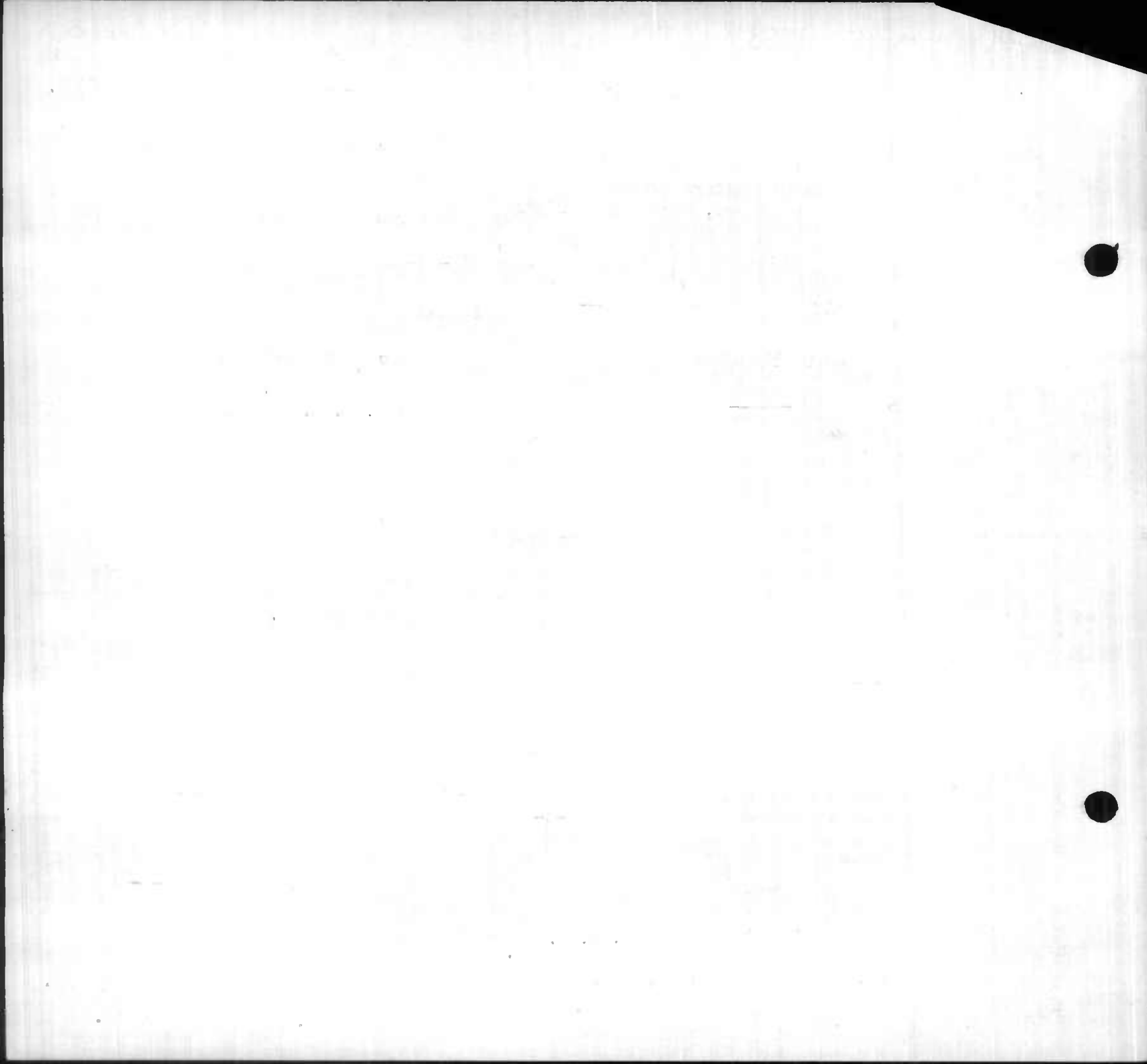
FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of a death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1368 | |
|--|---------|--|------------------|--|---|
| BIRTH NO. 65 1368 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Frances Czekalski | | 2-5-65 9:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | Maryland, Baltimore | | Balt | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Rural | |
| | | D. STREET ADDRESS (If rural, give location) | | 53700 | |
| | | 201 North Point Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min. |
| Female | White | Widowed | 10-15-81 | 83 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Poland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Walkowiak | | Josephine Palasko | | U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | RECORDS: B. C. H. 4940 Eastern Avenue #21224 | |
| 18. 1-20-0 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Arteriosclerotic Heart Disease | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2-1-65 | | Gangrene of Right Foot | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-30 19 65 to 2-5- 19 65 | | | | | |
| that (I) (we) last saw the deceased alive on 2-5- 19 65 | | | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| T. H. Moore Jr. | | | | 2-5-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| T. H. Moore Jr. | | Dr. T. H. Moore 4940 Eastern Avenue #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY | |
| Burial | | Feb 9 1965 | | Holy Cross Cemetery | |
| | | | | German Hill Road Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 8 1965 | | Robert E. Fisher, M.D. | | The Dippel Bros. 1800 E Lombard St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1369 | |
|--|--|--|--|--|--|
| BIRTH NO. 65 1369 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 2-4-65 11:15 P.M. | | | |
| 1. NAME OF DECEASED (Type or Print) LILLIAN C. CIARK. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| D. STREET ADDRESS (If rural, give location) | | E. AGE (In years last birthday) | | | |
| 5. SEX FEMALE | | 6. RACE COLORED | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | YEARS | |
| ANTECEDENT CAUSES | | (B) DUE TO | | YEARS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | RENAL INSUFFICIENCY | | YEARS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 6, 1964 to FEB. 4, 1965, that (I) (we) last saw the deceased alive on FEB. 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald A. Deimlin M.D. | | | | 23B. DATE SIGNED 2-5-65 | |
| 23C. PHYSICIAN'S NAME (Type) DONALD A. DEIMLIN M.D. | | | | 23D. ADDRESS MERCY HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |

V.S. 153

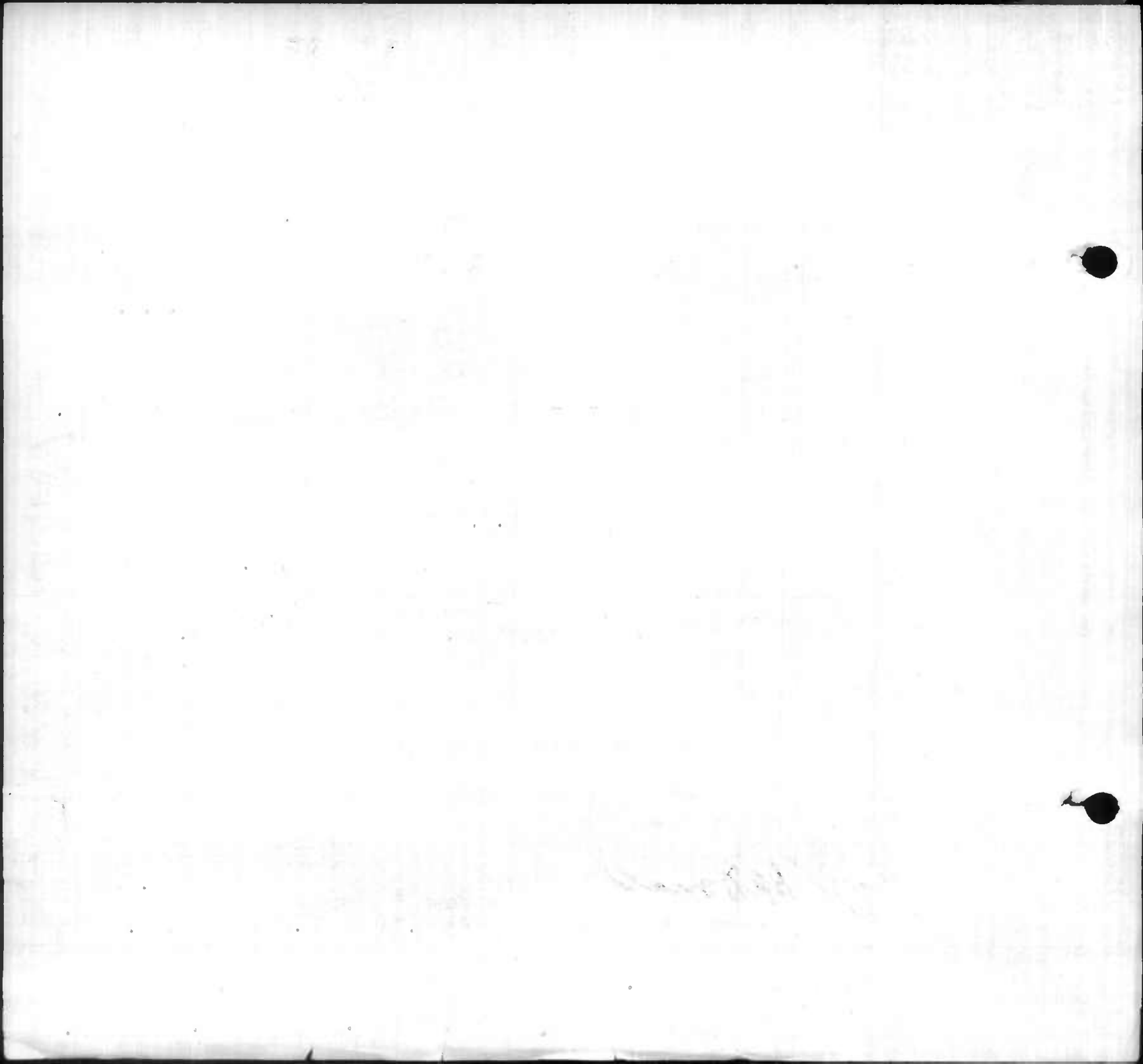
2-11-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

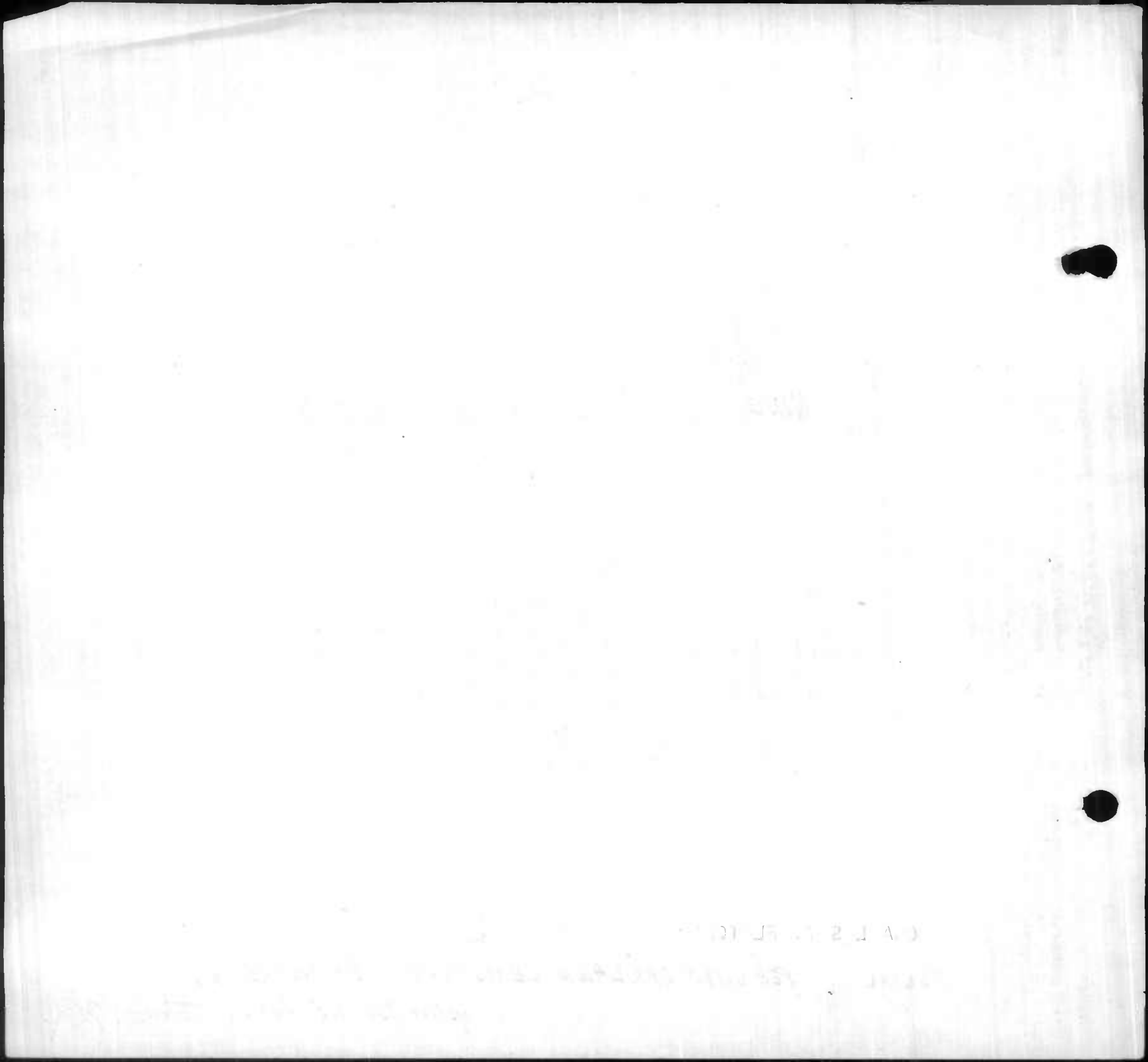
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1370</u> | |
|--|----------------------|---|---|--|--|
| BIRTH NO. <u>65 1370</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>WESLEY WINDHAM</u> | | | 2. DATE AND HOUR OF DEATH <u>2/5/65</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>PROVIDENT HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>16-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>913 HARLEM AVE.</u> | | |
| 5. SEX <u>M.</u> | 6. RACE <u>C.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>1/5/15</u> | 9. AGE (In years last birthday) <u>50</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>BEN WINDHAM</u> | | | 14. MOTHER'S MAIDEN NAME <u>MATTIE WELLS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>246-10-8460</u> | 17. INFORMANT <u>Willie Mae Windham 913 Harlem Ave.</u> | | |
| 18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Cerebral accident</u> DUE TO (B) <u>H.C.V</u> DUE TO (C) <u>Residual paralysis, Rt.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>?</u> <u>4 yrs</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | He had a convulsion at home. Taken to <u>Provident Hospt</u> where he died. | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 <u>64</u> to <u>Feb 1</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Feb 1</u> 19 <u>64</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>Medical examiner investigated</u> | | | | | |
| 23A. SIGNATURE <u>George McDonald</u> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Fe. 8, 1965</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>George Mc Donald</u> | | | 23D. ADDRESS <u>844 N. Carey St. Baltimore, Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/9/65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 8 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Charles A. Rice 661 W. Barre St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1371 | |
|---|-------------------|--|----------------------------|---|---|--|--|
| BIRTH NO. 65 1371 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Leo Hausner | | 2. DATE AND HOUR OF DEATH Feb 4, 1965 3:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence below admission) A. STATE Maryland B. COUNTY Balto | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Timonium | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 36 North Wood Drive | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 2-12-1986 | 9. AGE (in years (last birthday) 78 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? United States | | | |
| 13. FATHER'S NAME Franklin Hausner | | | | 14. MOTHER'S MAIDEN NAME Molly Dorsey | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Wm C Hausner 22 N. Wood Drive | |
| 18. I 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Acute Pneumonitis (B) Pulmonary Emphysema (C) Arteriosclerotic Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH 3 days 10-15 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cor Pulmonale | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 1, 1965 to Feb 4, 1965. that (I) (we) last saw the deceased alive on Feb 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Charles T. Fletcher M.D. | | | | 23B. DATE SIGNED Feb 4, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) CHARLES T. FLETCHER | | | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE FEB 6, 1965 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1372 | |
|---|-----------|---|--------------------------|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. 65 1372 | |
| BIRTH NO. 65 1372 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 2-3-65 8:45 A.M. | |
| 1. NAME OF DECEASED (Type or Print) MR. FRANKLIN LE GRAND | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) LUTHERVILLE 53-00 D. STREET ADDRESS (If rural, give location) 1521 PICKETT ROAD | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-14-10 | 9. AGE (In years last birthday) 54 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman. | | 10B. KIND OF BUSINESS OR INDUSTRY Morton Salt Co. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Robert R. LeGrand | | 14. MOTHER'S MAIDEN NAME Effie Myers | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Daughter ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Due to Sepsis from negative (B) Due to Urinary tract infection. (C) and infection of prostate gland. | | INTERVAL BETWEEN ONSET AND DEATH 2 days. Several weeks at least. 3 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 3-2-1-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH. | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-17-65 19 to 2-3 19 65, that (I) (we) last saw the deceased alive on 2-3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | | 23B. DATE SIGNED 2-3-65 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES N. POWDER M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE FEB. 6, 1965 | | 24C. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK | |
| 24D. LOCATION (City, town, or county) (State) PARKVILLE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR John Burns Sons Townson & Son, Inc. ADDRESS | | | |

James M. [unclear]
[unclear] [unclear]
[unclear] [unclear]

James M. [unclear]
[unclear] [unclear]
[unclear] [unclear]

James M. [unclear]
[unclear] [unclear]

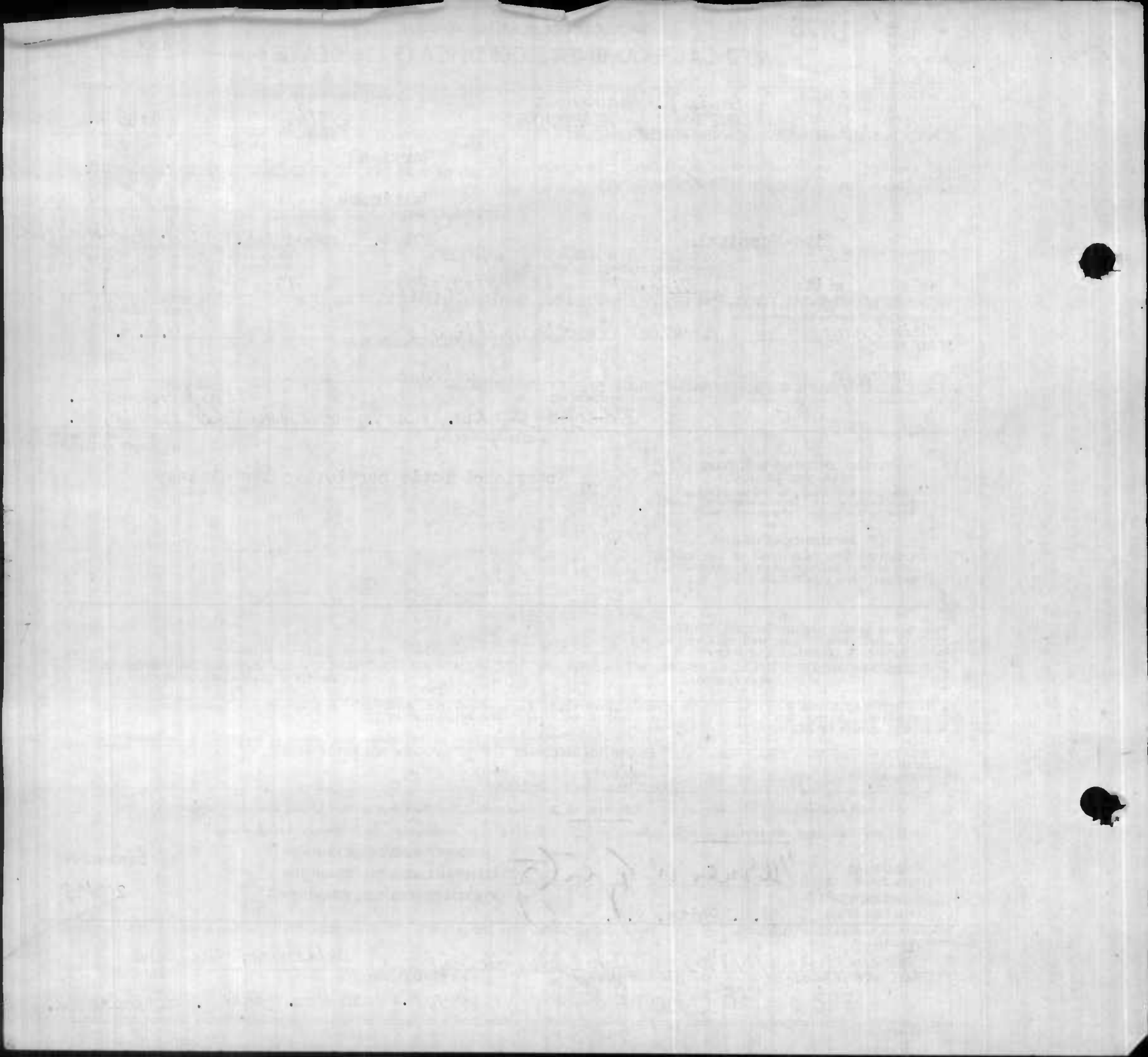
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 1373

BIRTH NO. 65 1373

M.E. CASE NO.

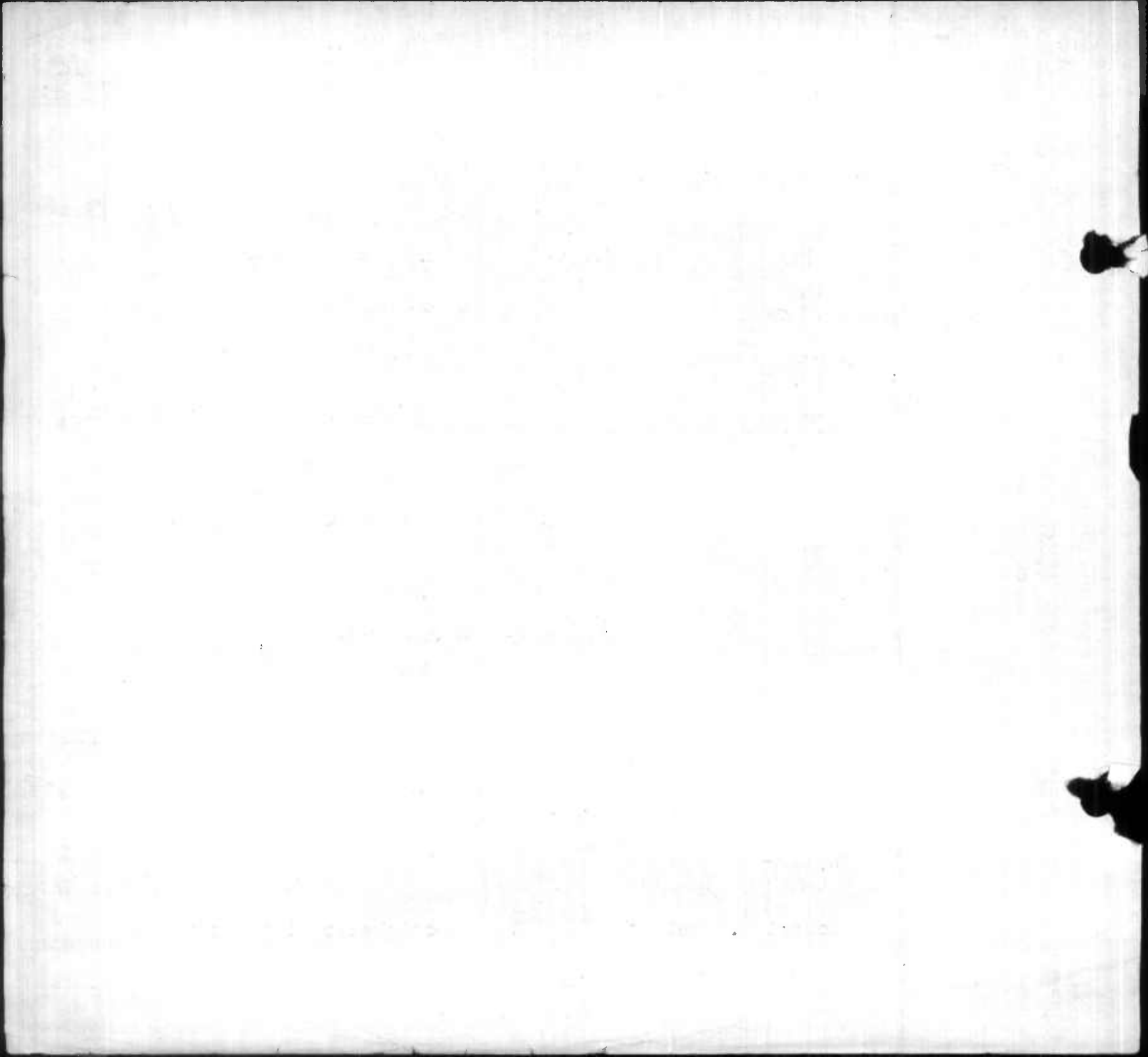
| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Louis C. Neaubouer</i> LOUIS MEAUBOUER | | 2. DATE AND HOUR PRONOUNCED DEAD <i>2/5/65</i> <i>1:45 a.</i> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>City Hospitals</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>101 S. Linwood Ave.</i> | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>2/12/1891</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>American Smelting</i> | 11. BIRTHPLACE (State or foreign country) <i>Illinois</i> |
| 13. FATHER'S NAME <i>unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>unknown</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>218-03-6438</i> | 17. INFORMANT <i>Mrs. Ella J. Nowakowski</i> |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH <i>Arteriosclerotic cardiovascular disease</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>no</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>W.U. Spitz, M.D.</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23B. DATE <i>2/8/1965</i> | |
| 23C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i> | | 23D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 24A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 24B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | |
| 24C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i> | | 24D. ADDRESS <i>3000 E. Baltimore St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

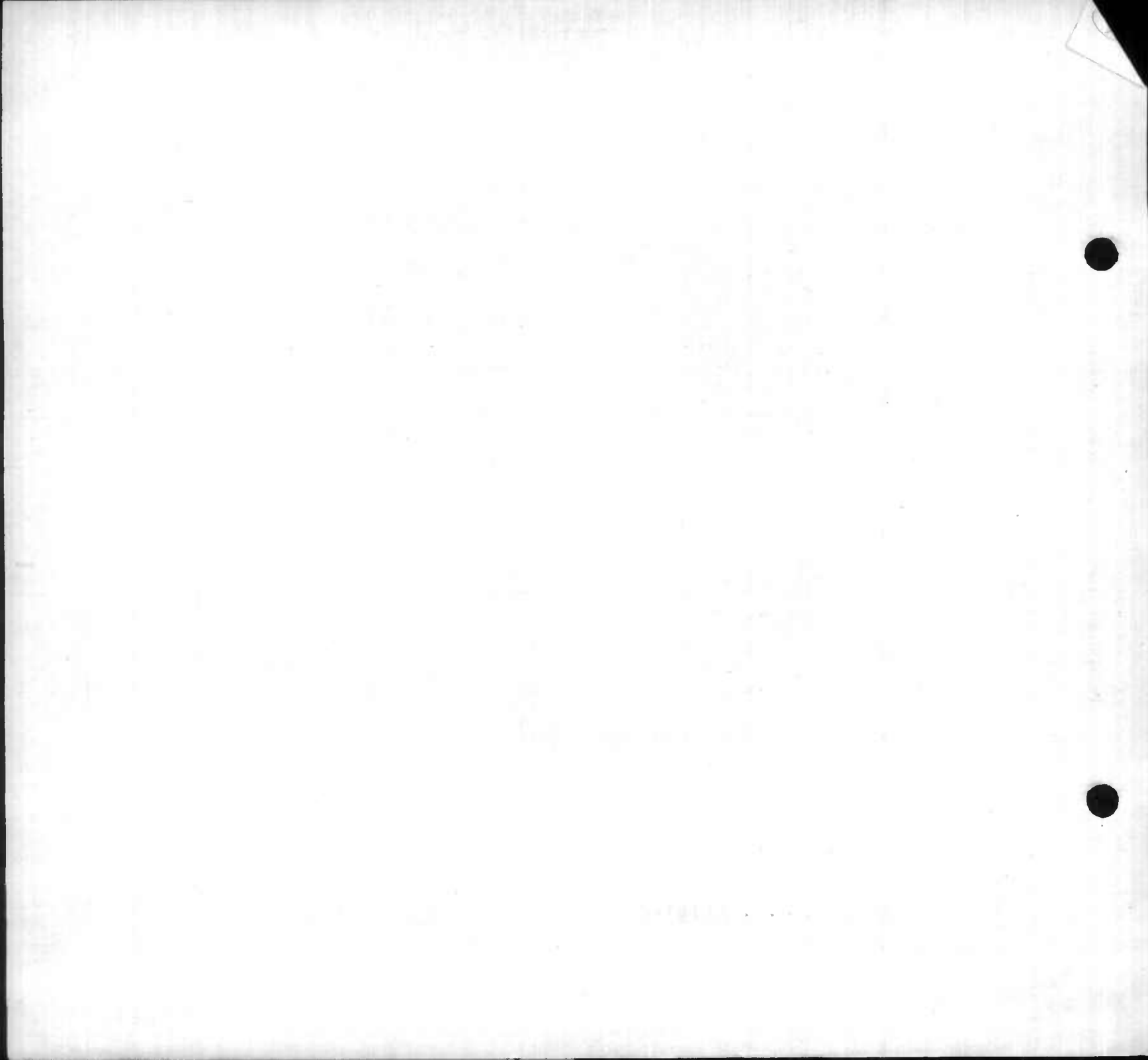
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------------|--|---------------------------------------|---|--|
| BIRTH NO. 65 1374 | | CERTIFICATE OF DEATH | | 65 1374 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Levi Frances</u> | | 2. DATE AND HOUR OF DEATH <u>2/6/65</u> <u>8:40</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Ind.</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>3308 Greenvale Rd.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>12/14/1886</u> | 9. AGE (In years last birthday) <u>78</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>Isaac Falk</u> | | 14. MOTHER'S MAIDEN NAME <u>Babette Hinkle</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>42-40-5889</u> | | 17. INFORMANT <u>Julius Levi</u> ADDRESS <u>3308 Greenvale Rd.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>331 X 4 260 X</u> | | CAUSE OF DEATH (A) <u>Respiratory arrest</u> DUE TO (B) <u>Bilateral cerebrovascular acc.</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>diabetes mellitus</u> | | | | | |
| 19A. DATE OF OPERATION <u>D</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> 19 <u>64</u> to <u>2/6</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>2/6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert W. Ireland</u> M.D. | | | | 23B. DATE SIGNED <u>2/6/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert W. Ireland</u> | | 23D. ADDRESS M.D. <u>Montebello State Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-7-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>CHEVRAAHAYAS CHESD</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 8 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Jack Lewis Inc</u> ADDRESS <u>2100 E. Tan Pl</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|--|---|--|-------------------------------------|
| 65-02495 | | 65 1375 | | 65 1375 4 | |
| BIRTH NO. | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| BABY BOY GIVENS | | | 2/1/65 2:55 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| UNIVERSITY HOSPITAL | | | Md. UNIVERSITY HOSPITAL | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| Baltimore 22-02 | | | 612 Houser St. #30 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. AGE (In years last birthday) |
| M | N | NEVER MARRIED | 1/31/65 | 13 | 9 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| CARDINAL GIVENS | | | DORETHA ROBINSON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| NO | | | | | UNIVERSITY HOSPITAL |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| I 776x IMMATURITY | | | 13 hrs 9 min | | |
| ANTECEDENT CAUSES | | | (A) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/31 19 65 to 2/1 19 65, that (I) (we) last saw the deceased alive on 2/1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| AB Heisler | | | | 2/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| A. A. B. Heisler | | | | UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. NAME OF CEMETERY OR CREMATORY | | 24C. LOCATION (City, town or county) (State) | |
| FEB 6 1965 | | ANATOMY BOARD OF MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 8 1965 | | Robert E. Taylor | | UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



BIRTH NO. 65 1376

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 1376

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George Danill

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 15, 1965

9:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

704 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 16, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION (City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 8 1965

Robert E. Farley, M.D.

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

VALLEY BOULDER

NO. 100

100

100

65 1377

BALTIMORE CITY HEALTH DEPARTMENT

65 1377

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY JONES

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1965 3:20 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital DOA

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

524 W. Hoffman St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

FEB 1 1965

23B. DATE

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION (City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

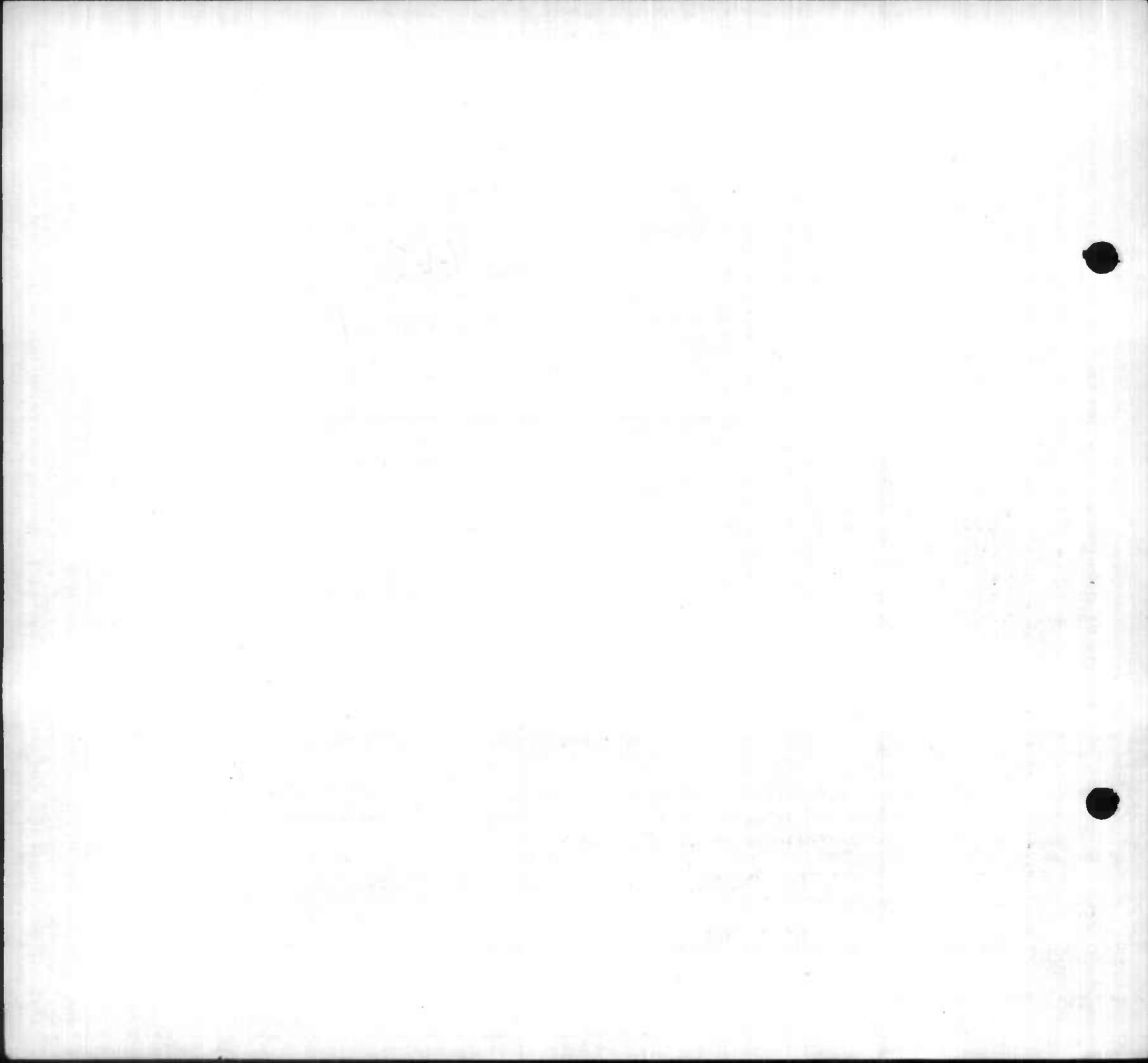
MORTUARY SERVICE - BCHD

WALLEY & POLINS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|-------------------------|--|--|----------------------------|--|------------------------------------|--|
| 65 1378 | | | | | 65 1378 | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>George E Terry</i> | | | | | 2. DATE AND HOUR OF DEATH <i>I-24-65 7:40 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN <i>BALTIMORE, MARYLAND</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>18-03</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>811 Hollins St.</i> | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH <i>6-6-65</i> | 9. AGE (In years, last birthday) <i>66?</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| 18. <i>381X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Intracerebral Hemorrhage</i> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>I-22 1965</i> to <i>I-24 1965</i> , that (I) (we) last saw the deceased alive on <i>I-24 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Rodrigo Toro</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>I-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Rodrigo Toro</i> | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>FEB 5 1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>ANATOMY BOARD OF MARYLAND</i> | | | 24D. LOCATION (City, town or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE</i> | | | 25D. ADDRESS <i>BCHD</i> | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

ELLEN T. McHARDY

2. DATE AND HOUR PRONOUNCED DEAD

February 2, 1965 9:00 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 29

D. STREET ADDRESS (If rural, give location)

102 N. Athol Avenue

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 21, 1890

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Nurse

11. BIRTHPLACE (State or foreign country)

Balto. Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Francis J. McHardy

14. MOTHER'S MAIDEN NAME

Della Bligh

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212 03 7078

17. INFORMANT

ADDRESS

Miss Mary McHardy, 102 N. Athol Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-3-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Feb. 6/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

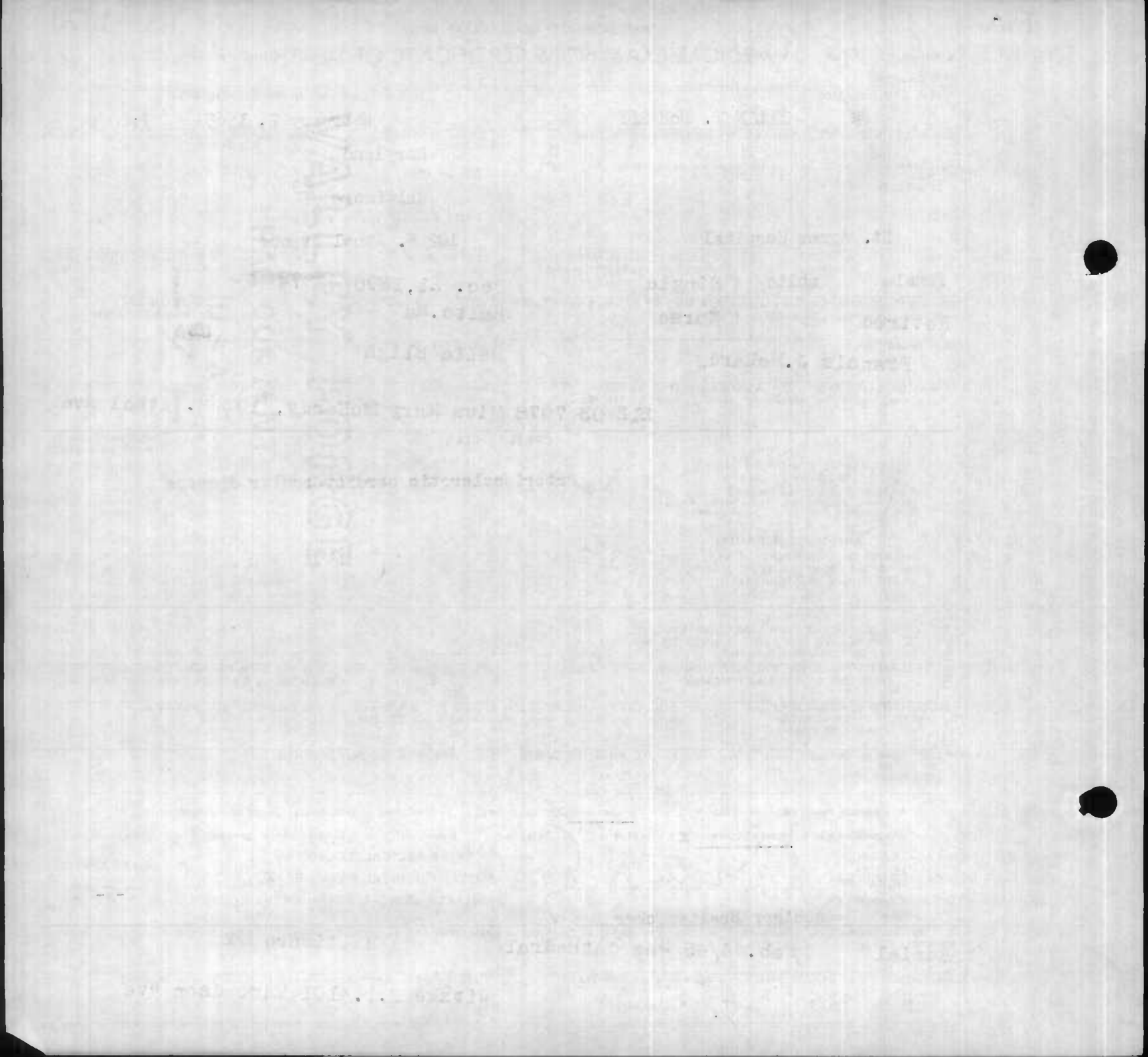
24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

ADDRESS

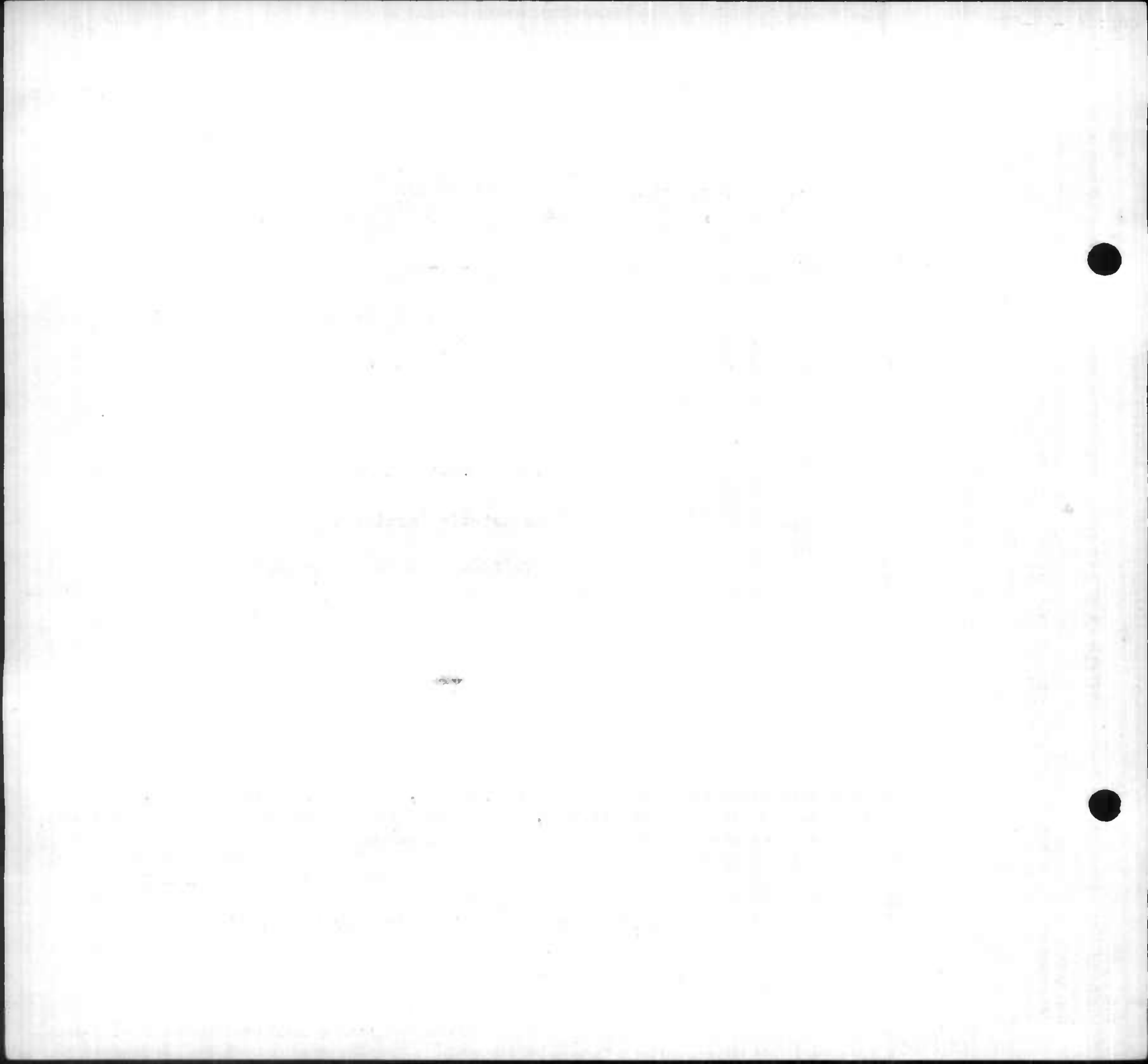


cdg: 42-18-581
R. 5-3-7

FUNERAL DIRECTOR: IMPORTANT

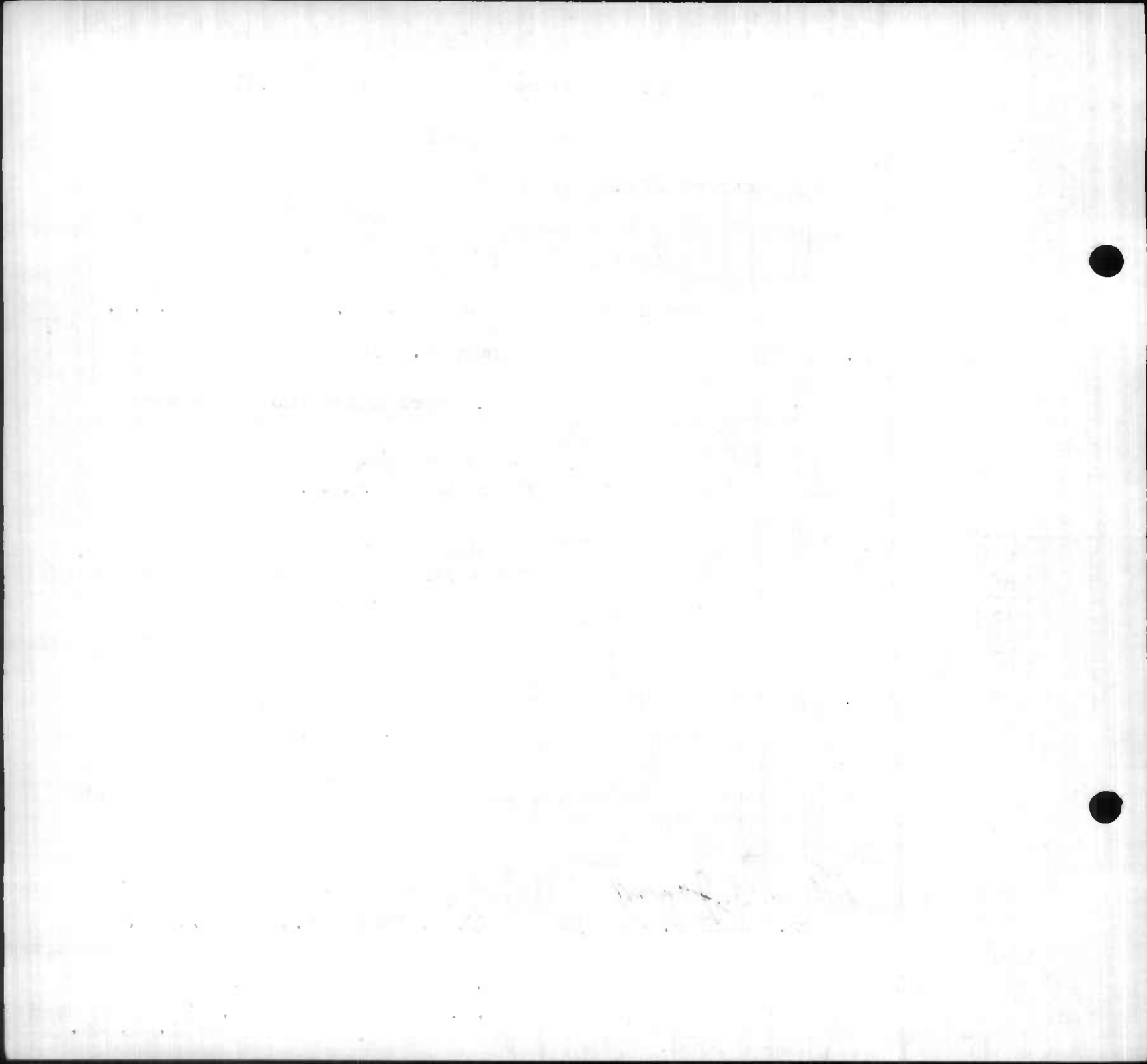
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1380 | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 65 1380 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Edith Randolph | | | 2. DATE AND HOUR OF DEATH February 6, 1965 10:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2030 Calvert Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 3-17-23 | 9. AGE (In years last birthday) 41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Alfred Steele | | | 14. MOTHER'S MAIDEN NAME Angelea Brison | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Thrombocytopenia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Carcinoma Probable Cerebral Hemorrhage | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 23, 1965 to February 6, 1965 , that (I) (we) last saw the deceased alive on February 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Cooke | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-6-65 |
| 23C. PHYSICIAN'S NAME (Type) Robert Cooke | | | 23D. ADDRESS 4940 Eastern Avenue 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-11-65 | 24C. NAME OF CEMETERY or CREMATORY Roland Green Mem Pl. | | 24D. LOCATION (City, town, or county) (State) Westchester Pa. |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR George H. Kuhn 1348 N. Calhoun St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

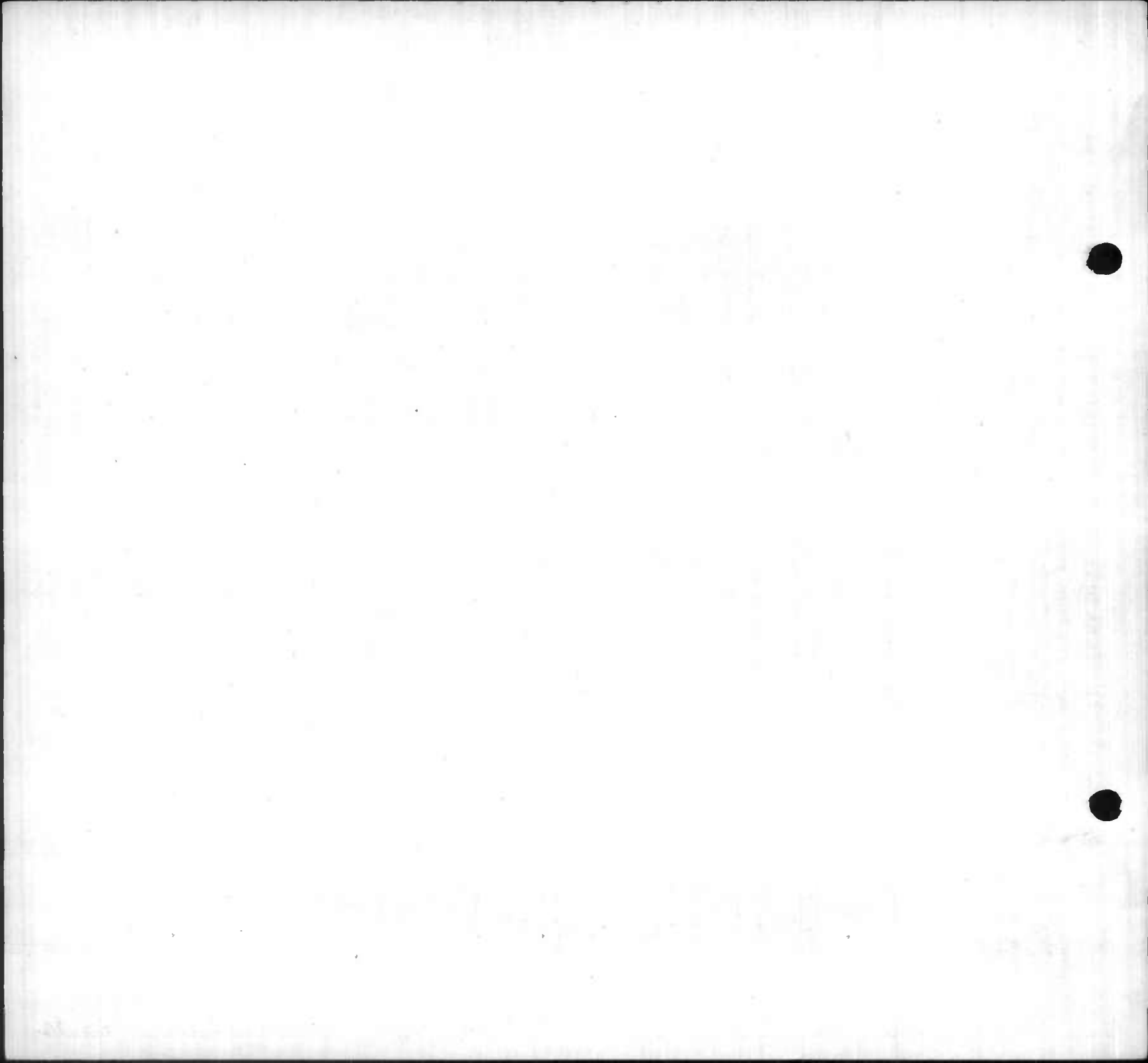
| | | | | | |
|--|--------------|--|------------------------------|--|---|
| BIRTH NO. 65 1381 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1381 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Lucretia Waters Milbourne | | February 6, 1965 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 27-14 | |
| 603 Somerset Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore (10) | |
| | | D. STREET ADDRESS (If rural, give location) | | 603 Somerset Road | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 2/8/1873 | 9. AGE (in years last birthday) 91 | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Own Home | | Kingston, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | John T. Waters | | Mary A. Ackworth | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | L. Waters Milbourne (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. CAUSE OF DEATH Myocardial infarction Generalized A.S.C.V.D. Anterior-lateral coronary Adenocarcinoma of uterus | | INTERVAL BETWEEN ONSET AND DEATH Sudden ? years July 1960. December 1963 | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 21. DATE OF OPERATION | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | 23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 24. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 25. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| | | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 27. HOW DID INJURY OCCUR? | |
| | | 28. I certify that (I) (my) (we) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 29. SIGNATURE Dr. Edwin B. Jarrett M.D. | |
| | | 30. DATE SIGNED 2/8/65. | | 31. ADDRESS 11 E. Chase St., Balto., Md. | |
| 32. BURIAL CREMATION, REMOVAL (Specify) | | 33. DATE | | 34. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/9/1965 | | Druid Ridge Cem. | |
| 35. LOCATION (City, town, or county) (State) | | 36. NAME of REGISTERED FUNERAL DIRECTOR | | 37. ADDRESS | |
| Pikesville, Maryland | | H.W. Jenkins & Sons Co. | | 4905 York Road Balto. 12, Md. | |
| 38. DATE REC'D BY HEALTH DEPT. | | 39. NAME OF REGISTERED FUNERAL DIRECTOR | | 40. ADDRESS | |
| FEB 8 1965 | | H.W. Jenkins & Sons Co. | | 4905 York Road Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

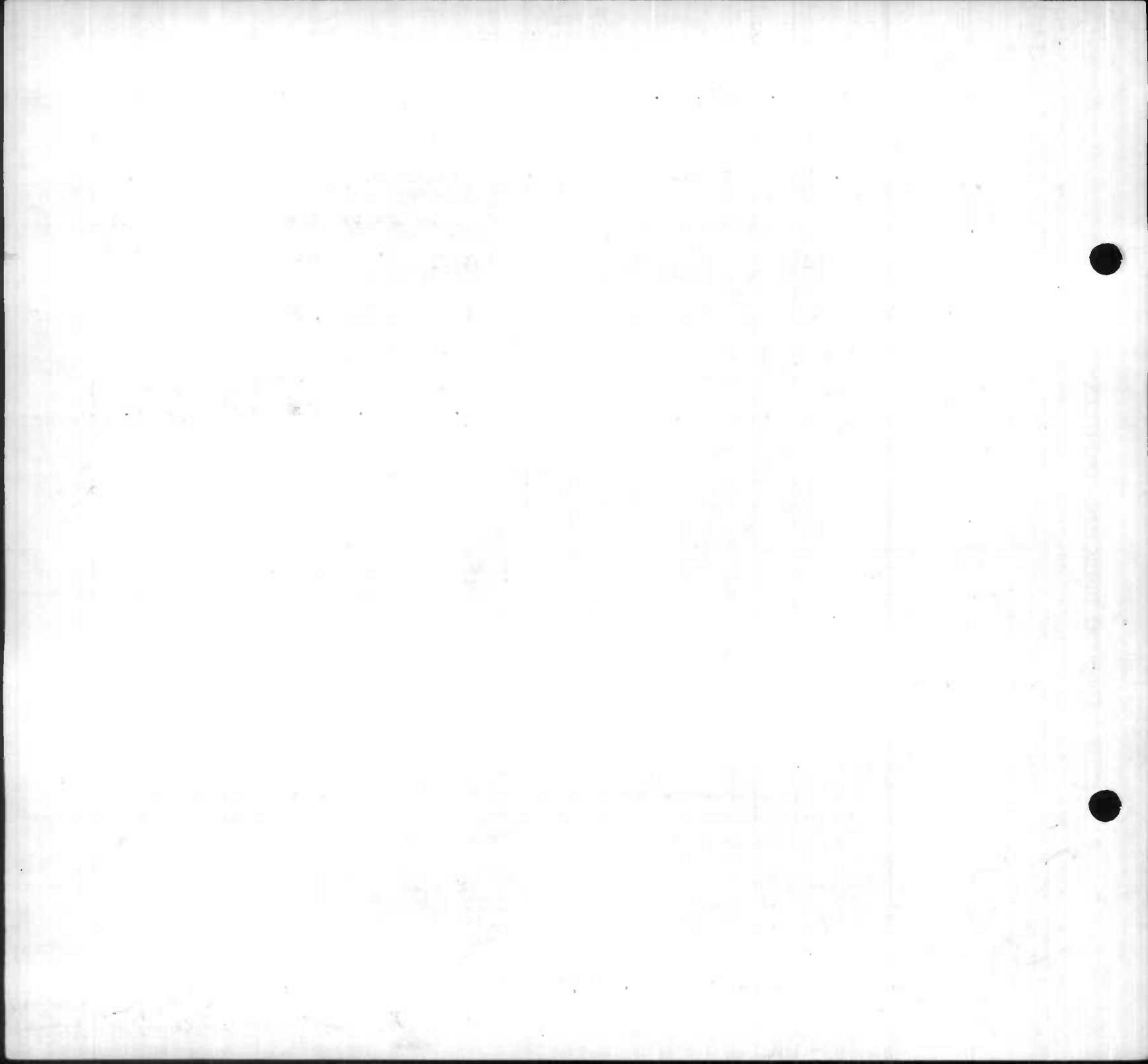
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1382 | |
|--|--|-------------------------|---|--|--|---|---|--|---------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 65 1382 | | | | | | | | | | | |
| M.E. CASE NO. 71840 | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Mr Charles S. Murphy | | | | | 2. DATE AND HOUR OF DEATH Feb. 6, 1965 2:30 PM | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours (If not in hospital or institution, give street address or location) | | | | | A. STATE Maryland | | | | | | |
| | | | | | B. COUNTY Balto | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 122 Humbarton Rd. | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 6-26-1891 | | 9. AGE (In years last birthday) 73 | | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS MGR | | | | | 10B. KIND OF BUSINESS OR INDUSTRY CATHOLIC REVIEW | | 11. BIRTHPLACE (State or foreign country) BALTO. MD | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Francis L. Murphy | | | | | 14. MOTHER'S MAIDEN NAME LETITIA NUGENT 7105 LIBERTY RD | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 215-03-7329A | | 17. INFORMANT CHARLES S. MURPHY JR. - 7105 LIBERTY ROAD | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1810 I | | | | | CAUSE OF DEATH (A) Carcinoma of the bladder 1962-1965 DUE TO with metastasis | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | | | |
| | | | | | (C) DUE TO | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 26 1965 to Feb 6 1965 , that (I) (we) last saw the deceased alive on Feb 6 1965 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Francisco Baltazar Jr. | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED Feb. 6, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Francisco Baltazar, Jr. | | | | | 23D. ADDRESS Staff - Bon Secours Hosp. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burn | | | 24B. DATE 2/4/65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR H.W. JENKINS & SONS Co. 4905 YORK RD 19 | | | ADDRESS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

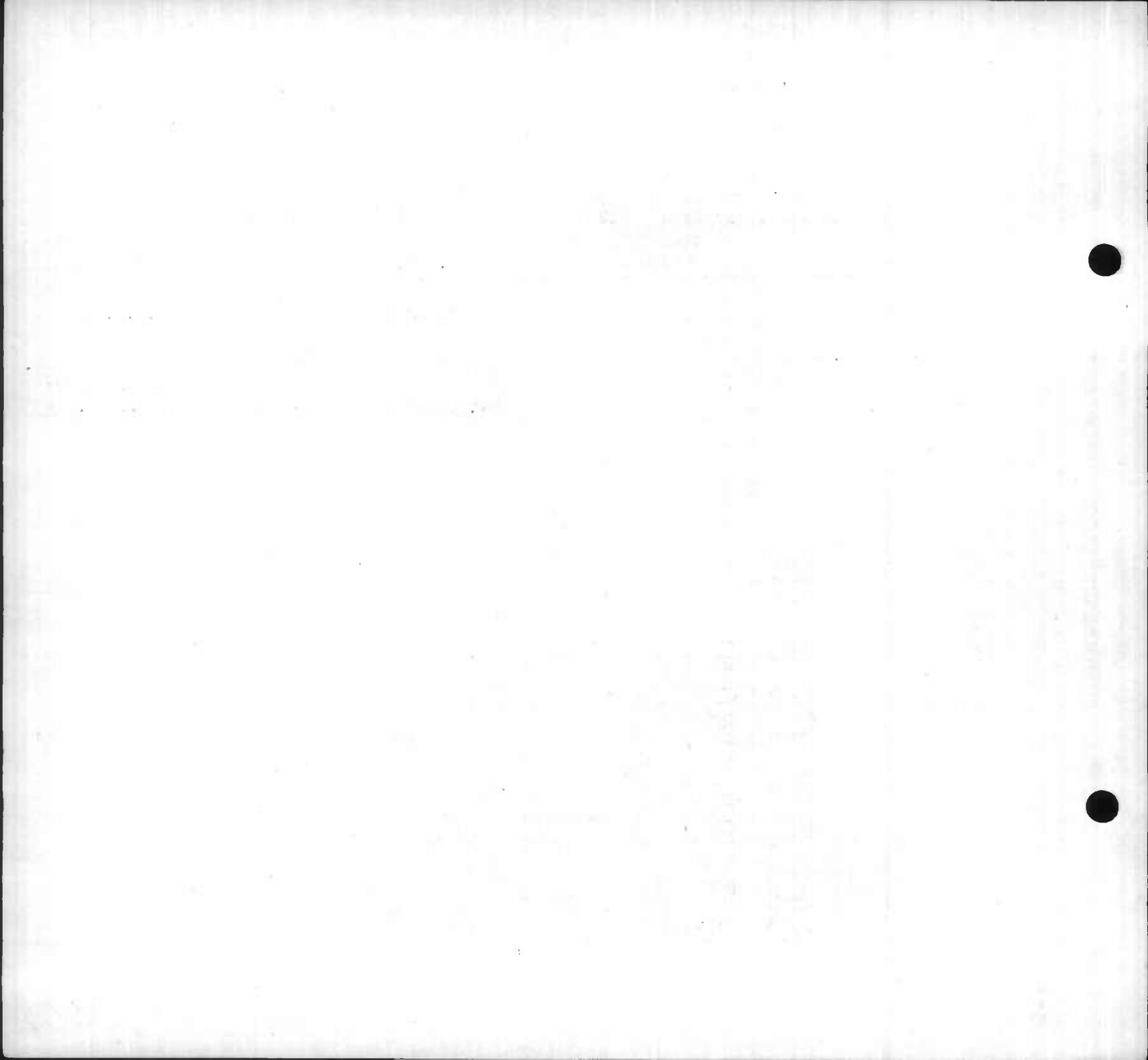
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1383</u> | |
|--|-------------------------------|--|--------------------------------------|---|---|
| BIRTH NO. <u>65 1383</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>February 6, 1965</u> <u>1740</u> M. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Thomas L. Davis, Sr.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-11</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Agnes Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3708 Egerton Road</u> <u>15</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>8/22/1899</u> | 9. AGE (In years last birthday) <u>65</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman H K K</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Charles County, Maryland</u> | |
| 13. FATHER'S NAME <u>Robert Sims David</u> | | 14. MOTHER'S MAIDEN NAME <u>Theodosia Long</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Marie G. Davis</u> ADDRESS <u>3708 Egerton Road Baltimore, Md. 15</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Coronary Occlusion</u> DUE TO (B) <u>Coronary</u> DUE TO <u>Arteriosclerosis</u> (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct 1964</u> to <u>Feb 6th 1965</u> , that (I) (we) last saw the deceased alive on <u>Feb 6 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. Paul Beyerly</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>M. Paul Beyerly</u> | | 23D. ADDRESS M.D. <u>5620 York Rd Baltimore 21212 MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>2/10/1965</u> | 24C. NAME of CEMETERY or CREMATORY <u>St. Marys Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Newport, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT <u>FEB 8 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Wm. J. Ticknair & Sons</u> ADDRESS <u>Baltimore, Md. 17</u> <u>North Park Avenue</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

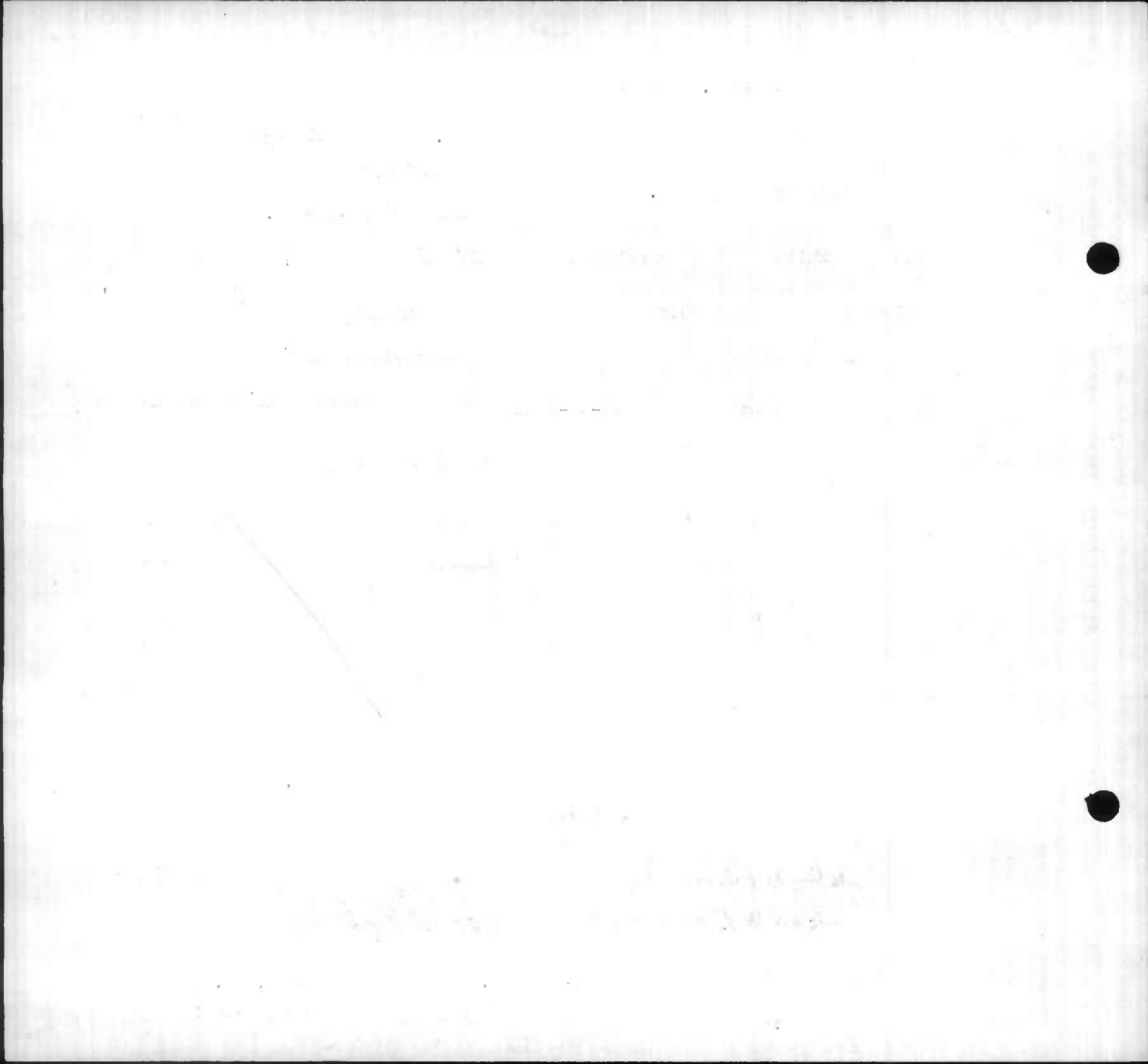
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1384 | |
|---|---|---|---|---|---|
| BIRTH NO. 65 1384 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lula O'Meara | | 2. DATE AND HOUR OF DEATH February 4, 1965 2³⁰ P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-15 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2211 West Rogers Avenue Methodist Home for the Aged Baltimore, Maryland 21209 | | D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue | | 9 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Sept. 20, 1877 | 9. AGE (in years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME James J. Goodman | | 14. MOTHER'S MAIDEN NAME Margaret Haddaway | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT 2211 W. Rogers Ave. Methodist Home for the Aged Balto., Md. 9 | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Osteoarthritis | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/> | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12 January 1965 to 4 February 1965 , that (I) (we) last saw the deceased alive on 2 February 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John W Barnaby | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 5 Feb 65 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY | | 23D. ADDRESS M.D. 1531 E North Ave Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/7/1965 | | 24C. NAME of CEMETERY or CREMATORY Chester Cemetery | |
| 24D. LOCATION Chestertown, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | |
| 25C. FUNERAL DIRECTOR Wm J. Johnson & Sons | | ADDRESS Baltimore, Md. 21217 North & Pa. Avenues | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1385 | | | | BALTIMORE CITY HEALTH DEPT. | | 65 1385 | |
|---|---------|--|-----------------------------------|--|--|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| William A. Bachman | | | | 5 Feb 65 | | 8:20 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | |
| 4111 Springdale Ave. | | | | Md. | | Baltimore | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 4111 Springdale Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Male | White | Married | 12/7/1884 | 80 | Estimator | Maryland | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| Estimator | | | Glass | | Maryland | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Marcus Bachman | | | | Catherine Schaab | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | None | | Miss Jane Bachman 4111 Springdale Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 443X I | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES | | | | (A) Cerebral thrombosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO | | | |
| | | | | (B) Hypertensive cardiovascular disease | | | |
| | | | | DUE TO | | | |
| | | | | (C) disease | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | If in Baltimore City, give exact location | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 18 January 1965 to 5 February 1965, that (I) (we) last saw the deceased alive on 5 February 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| John W. Barnaby | | | | | | 7 Feb 65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| John W. Barnaby | | | | 1531 E North Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2/8/1965 | | Woodlawn Cemt. | | Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 8 1965 | | Robert E. Taylor, M.D. | | Wm. J. Lockner, Son | | 1714 E. Baltimore Ave. | |



G 360

65 1386

BALTIMORE CITY HEALTH DEPARTMENT

65 1386

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

CHARLES ROSS GAITHER

2. DATE AND HOUR PRONOUNCED DEAD

February 6, 1965

1:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2117 Crimea Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1/5/1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

B and O RR

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Earle R. Gaither

14. MOTHER'S MAIDEN NAME

Annie E. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

705-05-3719

17. INFORMANT

Mrs. Walter Peterson

ADDRESS

13 Summerfield Road

Baltimore, Md.

7

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO and obesity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-7-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/9/1965

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Tichner & Sons Baltimore, Md. 17
North & Pa. Aves.

ADDRESS

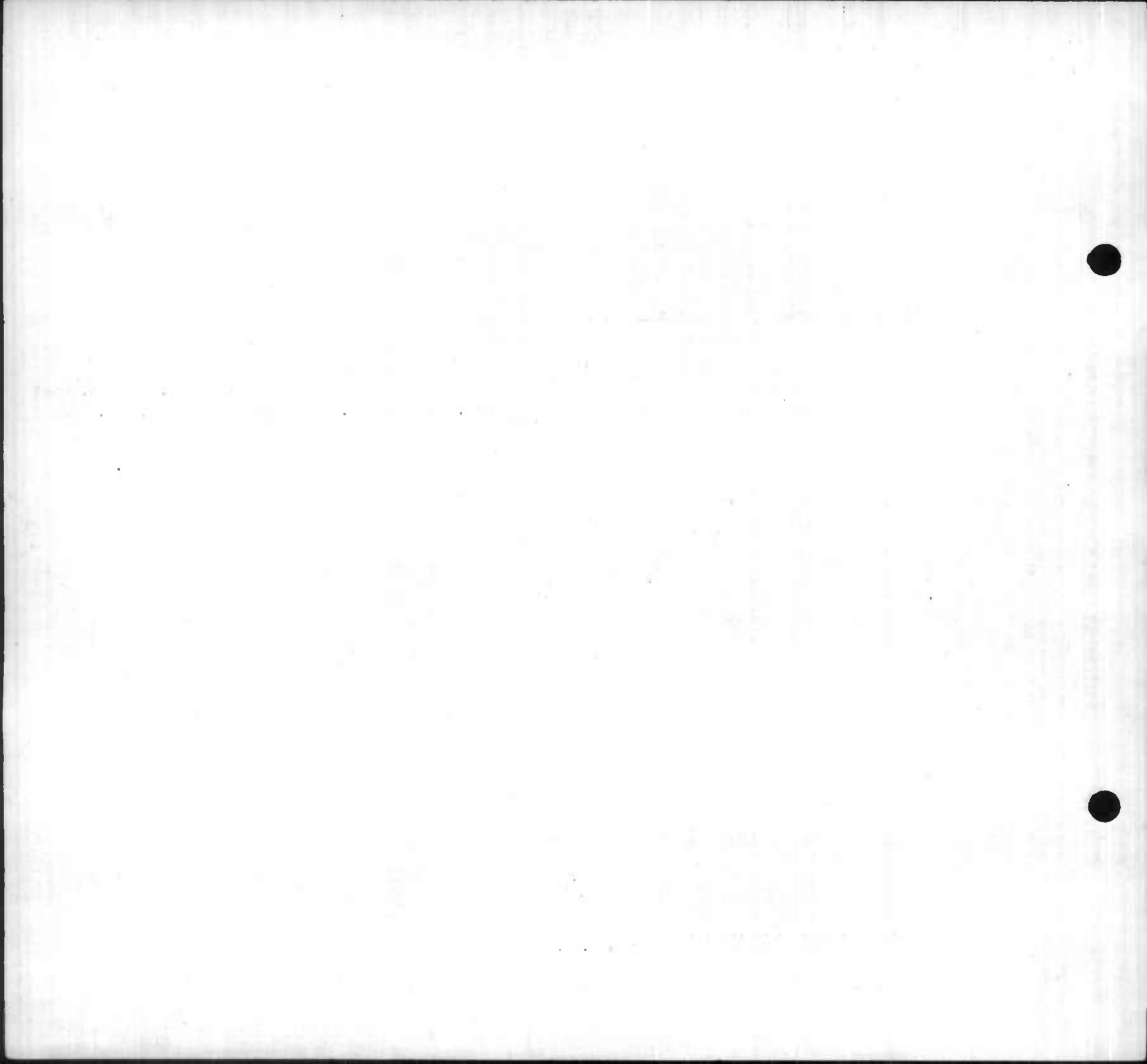
VALLEY FORD

W. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

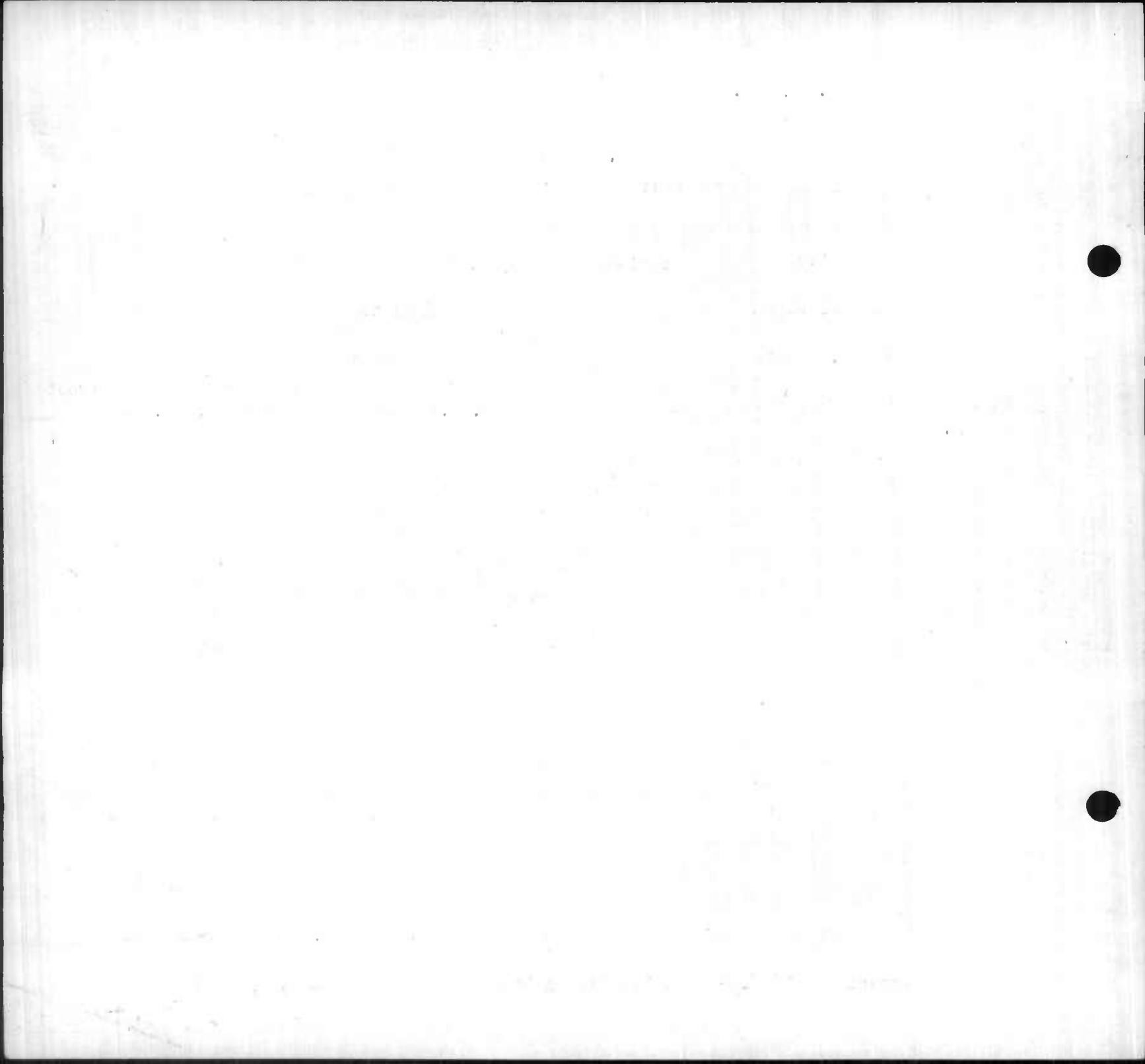
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1387 | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 65 1387 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) John Henry Rowley | | | 2. DATE AND HOUR OF DEATH FEBRUARY 5 1965 9:55 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12 02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3012 St. Paul St. 18 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/29/85 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Retail fuel | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME EUGENE Rowley | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. None | | |
| 17. INFORMANT Mrs. Dorothy R. Coleman Baltimore, Md. 18 | | | ADDRESS 3012 St. Paul Street | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO 6 days | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1/30 1965 to FEBRUARY 5 1965 , that (I) (we) last saw the deceased alive on FEBRUARY 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David Merritt Mac Millan M.D. | | | | 23B. DATE SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID MERRITT MAC MILLAN, M.D. | | | | 23D. ADDRESS Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/8/1965 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Wm. F. Richmond Sons Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

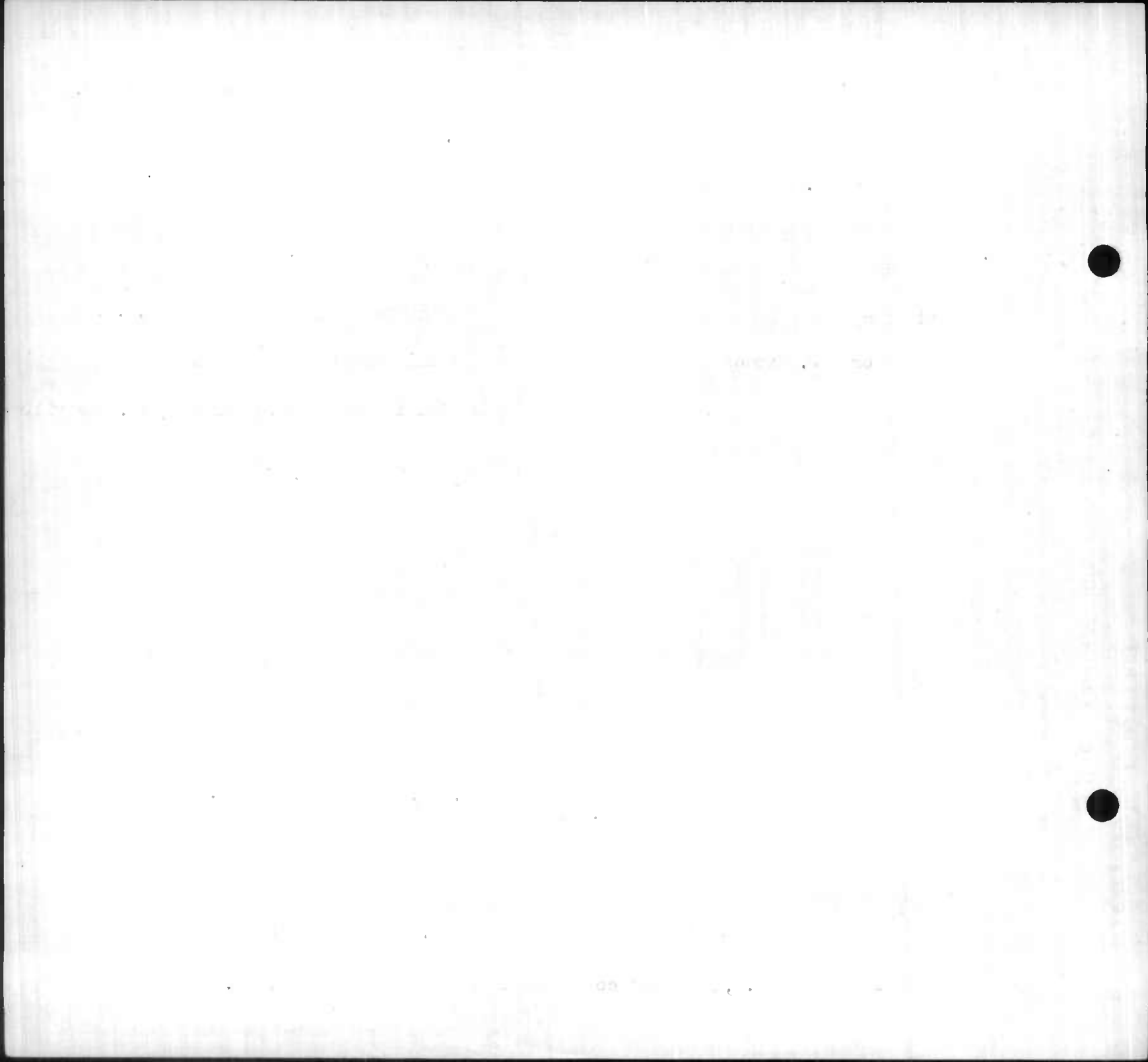
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1388 | |
|--|-------------------------|--|---|--|--|--|------------------------------|--|---|---|--|
| CERTIFICATE OF DEATH X | | | | | | | | | | | |
| BIRTH NO. 65 1388 | | | | | | | | | | | |
| M.E. CASE NO. Dr. Amos R. Koontz | | | | | | | | | | 2. DATE AND HOUR OF DEATH February 3, 1965 M. | |
| 1. NAME OF DECEASED (Type or Print) | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 East Eager Street | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Garrison | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 5300 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/12/1890 | 9. AGE (In years last birthday) 74 | II Under 1 Yr. Months: Days: Hours: Min. | | II Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician - self | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Virginia | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Hubert L. Koontz | | | 14. MOTHER'S MAIDEN NAME Annie Brown | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I & II | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mr. W. Burton Guy | | | ADDRESS 101 West Monument Street Baltimore, Md. 1 | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) 5 Minutes DUE TO (C) 5 Minutes INTERVAL BETWEEN ONSET AND DEATH 5 Minutes | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) was last saw the deceased alive on Feb 3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Robert C. Kimberly | | | | | | | | | | 23B. DATE SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) Robert C. Kimberly | | | | | | | | | | 23D. ADDRESS 1014 St. Paul St., Baltimore 2, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | | 24B. DATE 2/7/1965 | | | 24C. NAME OF CEMETERY or CREMATORY Graves Chapel Cemetery | | | 24D. LOCATION (City, town, or county) (State) Stanley, Virginia | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | | 25C. FUNERAL DIRECTOR Wm. J. Fickner & Son | | | ADDRESS Baltimore, Md. 17 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--|--|--|--|--|
| BIRTH NO. 65 1389 | | CERTIFICATE OF DEATH | | 65 1389 | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ROBERTSON, LENA | | February 6, 1965 12:35 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | A. STATE Md. B. COUNTY Baltimore | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 2/6/87 | | 9. AGE (In years last birthday) 78 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George W. Maddox | |
| 14. MOTHER'S MAIDEN NAME Sallie Sudler | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Miss Sallie Robertson | | ADDRESS 6 Waldron Ave. Pikesville | | | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Atherosclerotic Heart Disease | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 28, 1965 to Feb. 6, 1965 | | that (I) (we) last saw the deceased alive on Feb. 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Salvadore Marse | | M.D. Attending Phys. Med. Director Staff Phys. X | | 23B. DATE SIGNED 2/6/65 | |
| 23C. PHYSICIAN'S NAME (Type) Salvadore Marse | | 23D. ADDRESS 1400 N. Caroline Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE Feb. 8, 1965 | | 24C. NAME of CEMETERY or CREMATORY Episcopal Cemetery | |
| 24D. LOCATION Fairmount, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Severin P. Wilson, P. Carme, M.D. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 1390

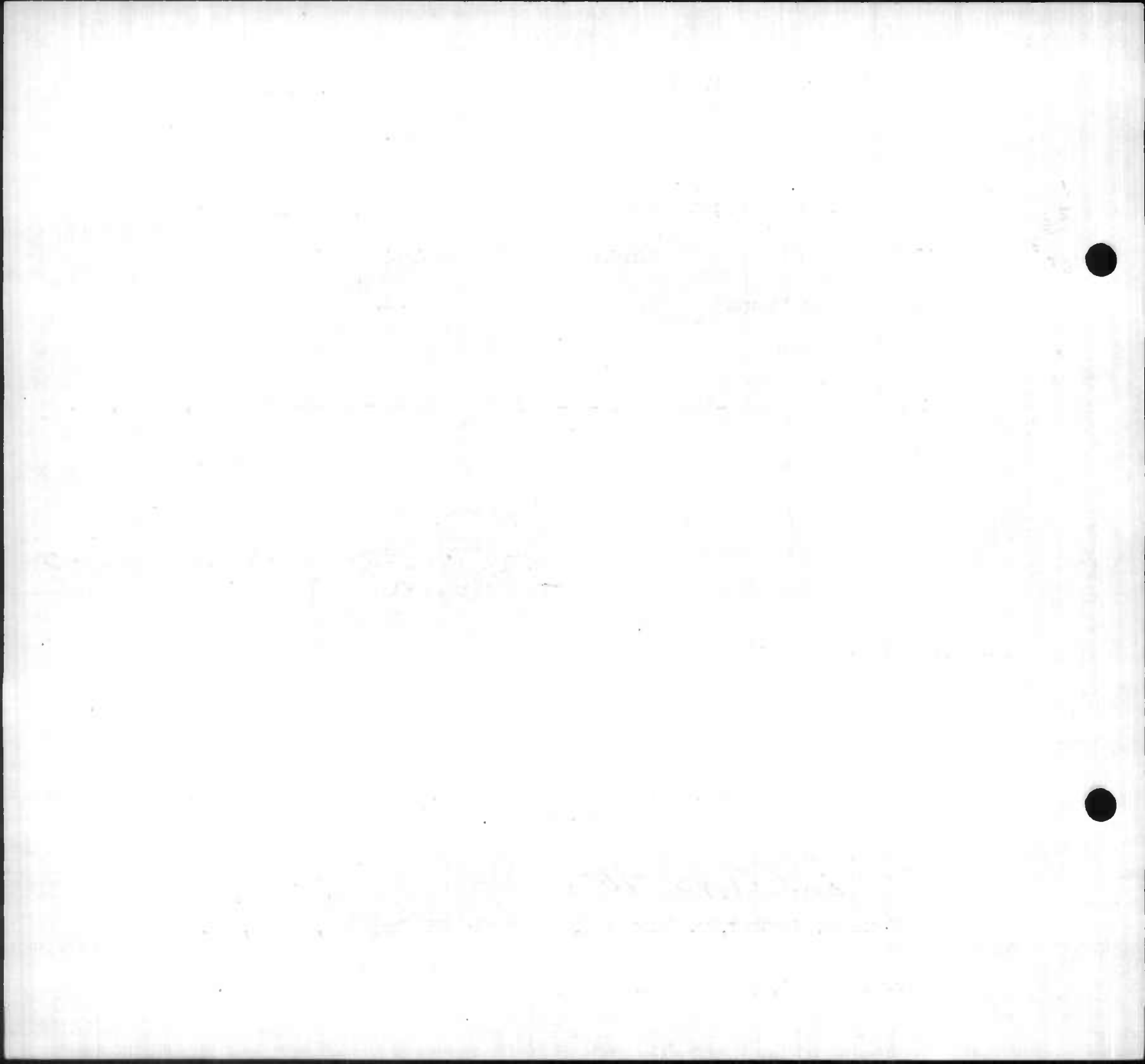
| | | | |
|--|------------------|---|---------------------------------|
| BIRTH NO. 65 1390 | | 2. DATE AND HOUR OF DEATH FEBRUARY 4 1965 11:50 A.M. | |
| M.E. CASE NO. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | |
| 1. NAME OF DECEASED (Type or Print) Mr. Alfred M. Scott | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4531 Marble Hall Rd. Baltimore 12 | | D. STREET ADDRESS (If rural, give location) 4531 Marble Hall Road 12 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 3 1878 |
| 9. AGE (In years last birthday) 87 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive | | 10B. KIND OF BUSINESS OR INDUSTRY Banking | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Scott | | 14. MOTHER'S MAIDEN NAME Jane Dyson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Jessie Scott | | ADDRESS as Above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION Sudden | | INTERVAL BETWEEN ONSET AND DEATH 54 YEARS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARDIO-VASCULAR DISEASE | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 60 to FEBRUARY 4, 19 65, that (I) (we) last saw the deceased alive on FEBRUARY 4, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Arthur Karfagin | | 23B. DATE, SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) ARTHUR KARFAGIN | | 23D. ADDRESS 1532 HAVENWOOD ROAD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 2/8/65 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) Macon, Georgia | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR William J. Tucker + Sons North + Palmer | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

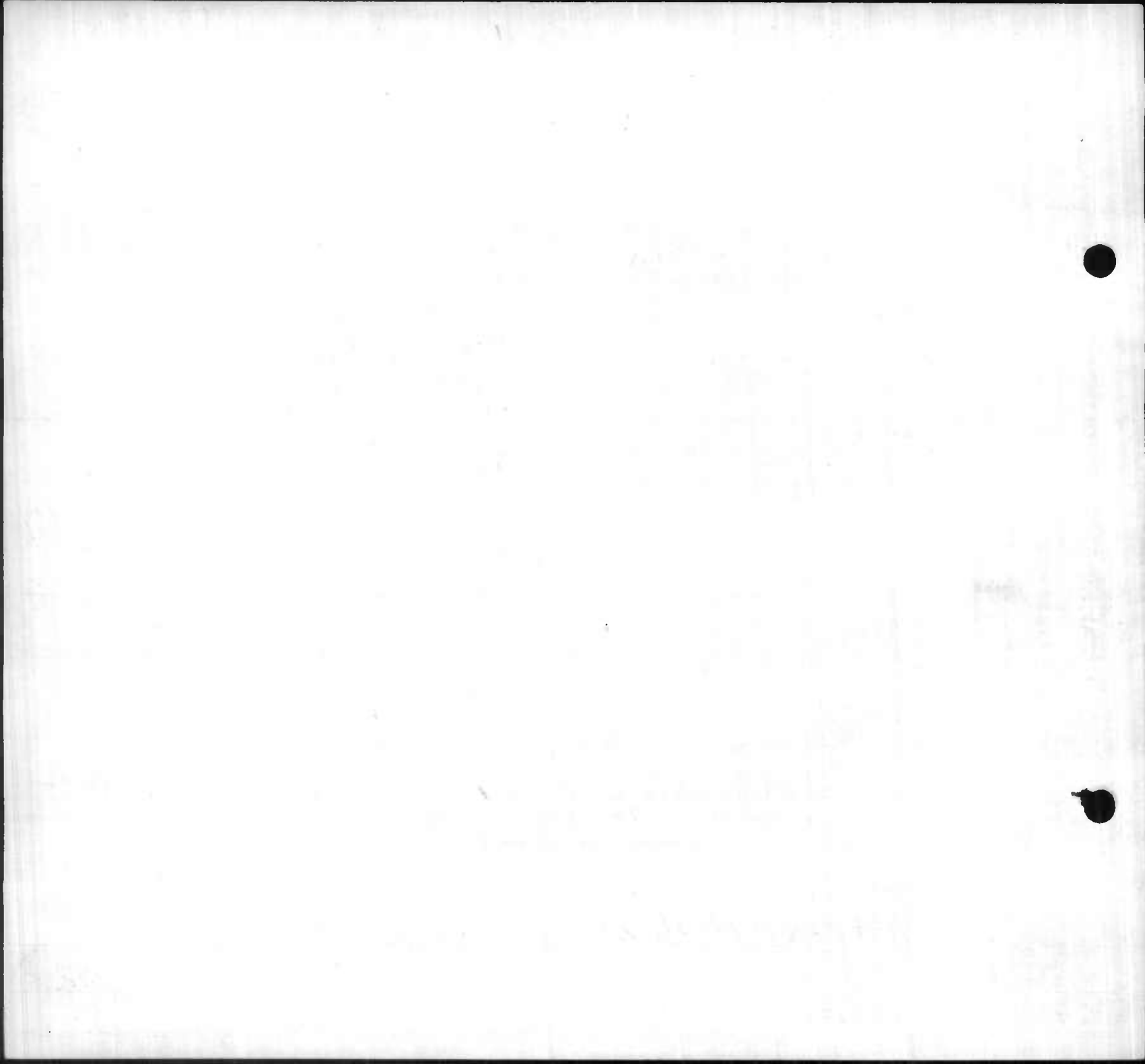
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1391 | |
|---|---|---|---|--|--|
| BIRTH NO. 65 1391 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ISIDOR MORTIZ POSS | | | 2. DATE AND HOUR OF DEATH Feb. 5, 1965 2:50 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | A. STATE Md. B. COUNTY 11-04 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 213 W. Lanvale Street | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 9/14/94 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commodore Sea Scouts | | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Moses Poss | | | 14. MOTHER'S MAIDEN NAME Bertha Eckhaus | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1918-1919 | | | 16. SOCIAL SECURITY NO. 212-22-5613 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | | CAUSE OF DEATH CONGESTIVE HEART FAILURE TERMINAL | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH MYOCARDIAL INFARCT RECENT | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) ARTERIOSCLEROTIC CARDIO YEARS 5 TO VASCULAR DISEASE | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 5 19 65 to Feb. 5 19 65 , that (I) (we) last saw the deceased alive on Feb. 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frank A. Bartkus M.D. | | | | 23B. DATE SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) Frank A. Bartkus, Sr. Surgeon (R) M.D. | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/7/65 | | 24C. NAME OF CEMETERY or CREMATORY Oheb Shalom | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS William J. Zuckew + Sons North + Penna | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1392 | |
|--|------------------------|--|--------------------------------------|---|---|
| BIRTH NO. 65 1392 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Darius Thompson</i> | | 2. DATE AND HOUR OF DEATH <i>2-7-65</i> <i>2:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>20-01</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>1812 W. Saratoga St</i> | | D. STREET ADDRESS (If rural, give location) <i>1812 W. Saratoga St</i> | | | |
| 5. SEX <i>Fe</i> | 6. RACE <i>Col.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>7-26-1880</i> | 9. AGE (In years last birthday) <i>84</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Wm B. Holland</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Golden</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Andrews Thompson - Churchton, md</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Coronary Occlusion</i> (B) <i>Cerebral Hemorrhage</i> (C) <i>Arteriosclerotic Heart Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i> <i>Unknown</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-28-1965</i> to <i>2-7-1965</i> , that (I) (we) last saw the deceased alive on <i>2-7-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Richard H. Hunt</i> M.D. | | | | 23B. DATE SIGNED <i>2/8/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>RICHARD H. HUNT</i> M.D. | | | | 23D. ADDRESS <i>1607 W. Mulbury</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-11-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Franklin Chapel</i> | |
| 24D. LOCATION <i>Deale</i> | | 24E. (City, town, or county) <i>md</i> | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Wm. J. J. Annopolis, md</i> | |



1
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65 1393

BALTIMORE CITY HEALTH DEPARTMENT

65 1393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM HOWARD

2. DATE AND HOUR PRONOUNCED DEAD

February 6, 1965 9:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

304 Old Trail Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

May 2, 1914

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

General Manager

10B. KIND OF BUSINESS OR INDUSTRY

Herring Jeep

11. BIRTHPLACE (State or foreign country)

Roseboro, N. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Howard

14. MOTHER'S MAIDEN NAME

Lena Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

069-05-1618

17. INFORMANT

Mrs. Helen K. Howard

ADDRESS

same

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, lmn, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-7-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/9/65

23C. NAME OF CEMETERY / CREMATORY

Dulaney Valley
Moreland Memorial Pk.

23D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Rd.

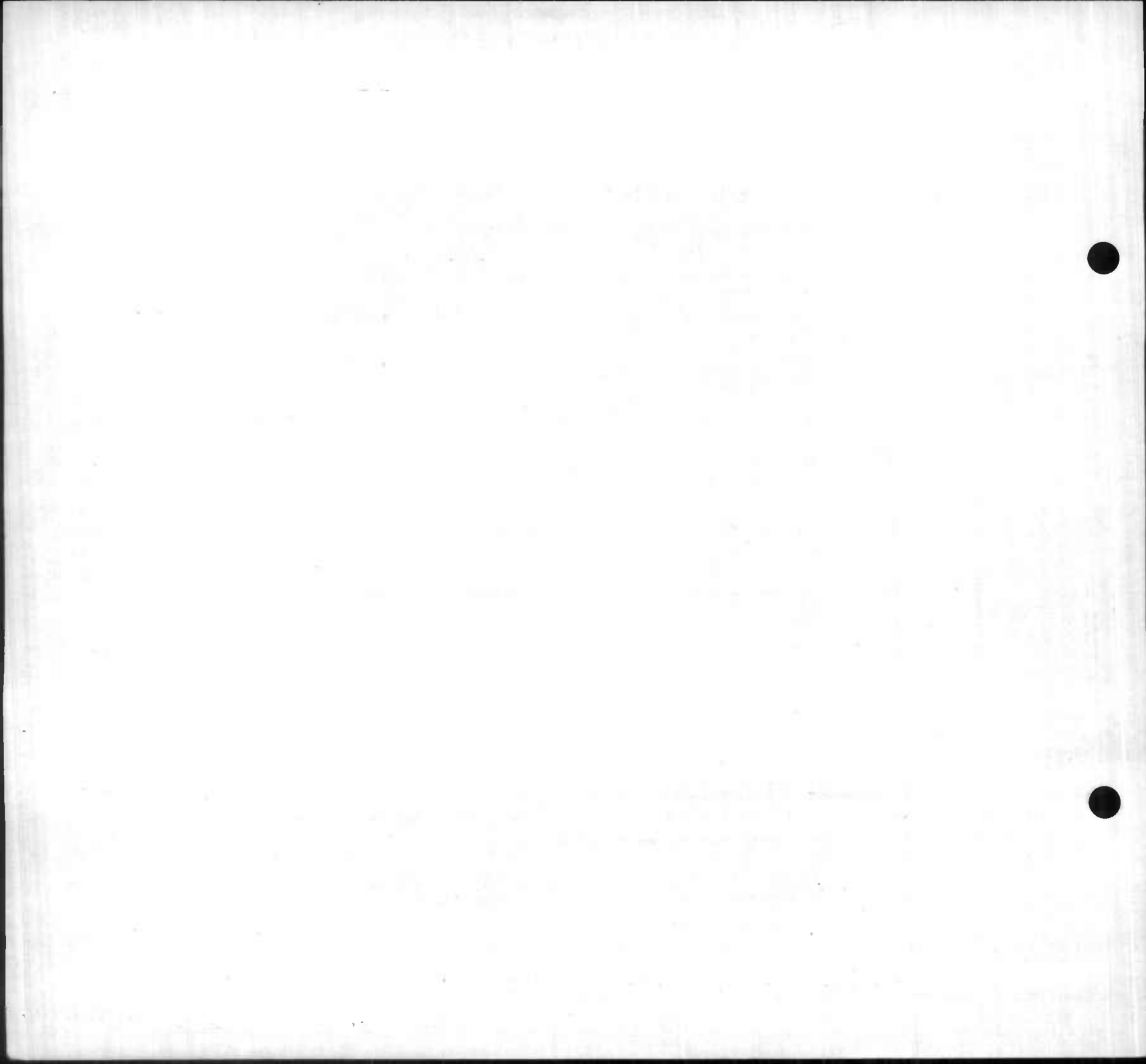
ADDRESS

Robertson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

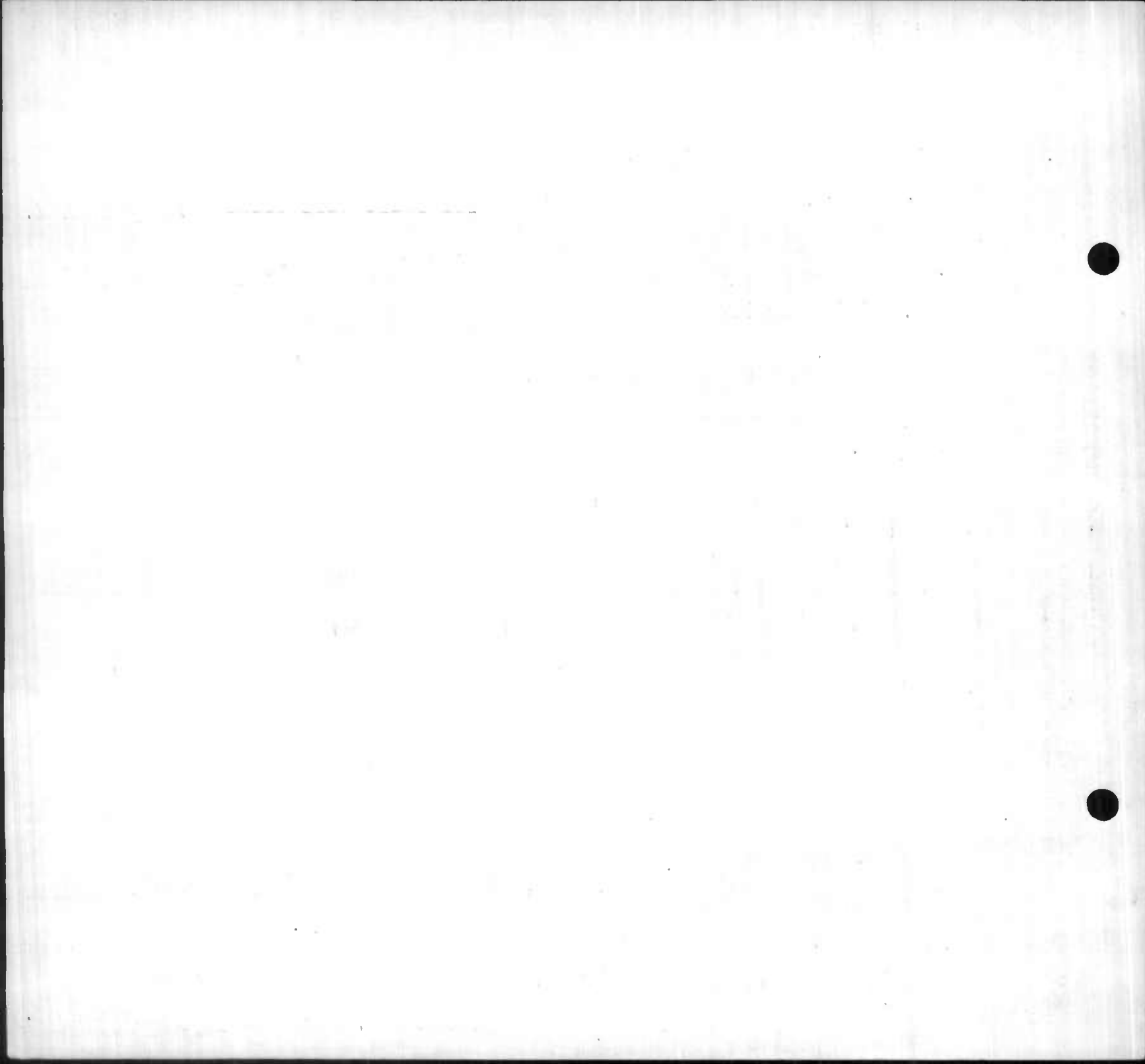
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1394 | |
|---|---------------------|---|--------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 65 1394 | |
| BIRTH NO. 65 1394 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Mardaga Fannie Gertrude | | 2-7-65 3 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital | | A. STATE Maryland B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 4301 Roland Avenue | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 3-10-1874 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Henry Kreis | | 14. MOTHER'S MAIDEN NAME Ellen J. Bond | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-05-0128-D | | 17. INFORMANT ADDRESS Hospital Record Jenkins Memorial | |
| 18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 7/31 19 65 to Feb 7 19 65 , that (H) (we) last saw the deceased alive on 2/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Raymond Gladue M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 2/7/65 | |
| 23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue M.D. | | | | 23D. ADDRESS Jenkins Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/10/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc 5305 Harford Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

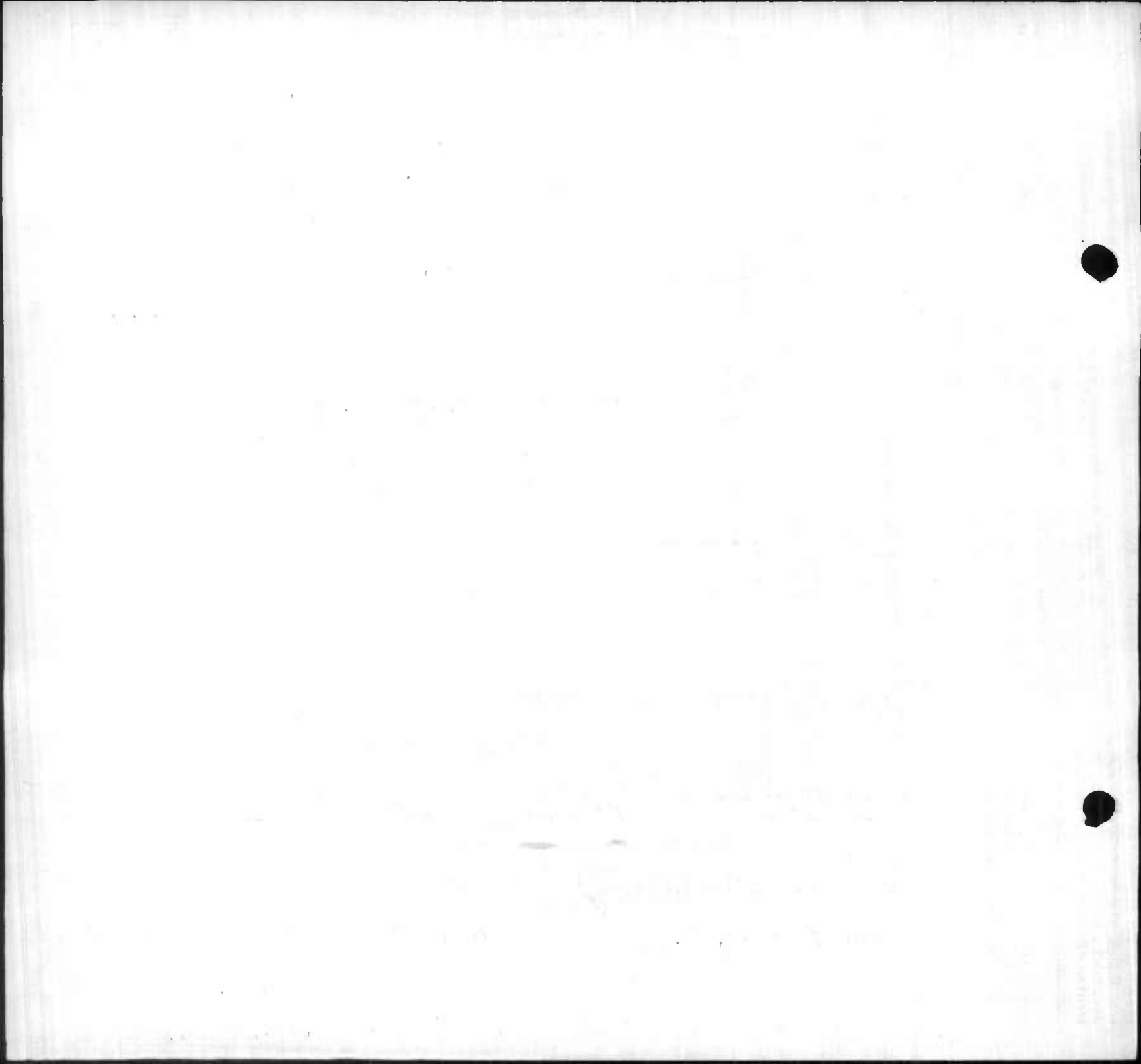
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1395 | |
|---|------------------|---|--------------------------------------|--|---|
| BIRTH NO. 65 1395 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Jacobson, Carl</i> | | | |
| 2. DATE AND HOUR OF DEATH | | <i>February 8, 1965 3:40 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> B. COUNTY <i>9-04</i> | | | |
| <i>Franklin Square Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>-5102 - Gaither - Rt 610 E/ 27th St.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Bachelor</i> | 8. DATE OF BIRTH <i>12/7/1897</i> | 9. AGE (In years last birthday) <i>67</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Civil Service</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Ohio</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Jacob Jacobson</i> | | 14. MOTHER'S MAIDEN NAME <i>Tennison</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Lewis Jacobson</i> | |
| 18. <i>420.1 I</i> | | CAUSE OF DEATH | | ADDRESS <i>5218 The Alameda</i> <i>phone JO 3-1539</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) <i>myocardial infarction</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 5</i> 19 <i>65</i> to <i>Feb. 8</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Feb. 8</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Kyo Rak Lee</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>2/8/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Kyo Rak Lee</i> | | 23D. ADDRESS <i>Franklin Square Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/14/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lakeview Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Port Clinton, Ohio</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | |
| | | | | ADDRESS <i>5305 Harford Rd.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

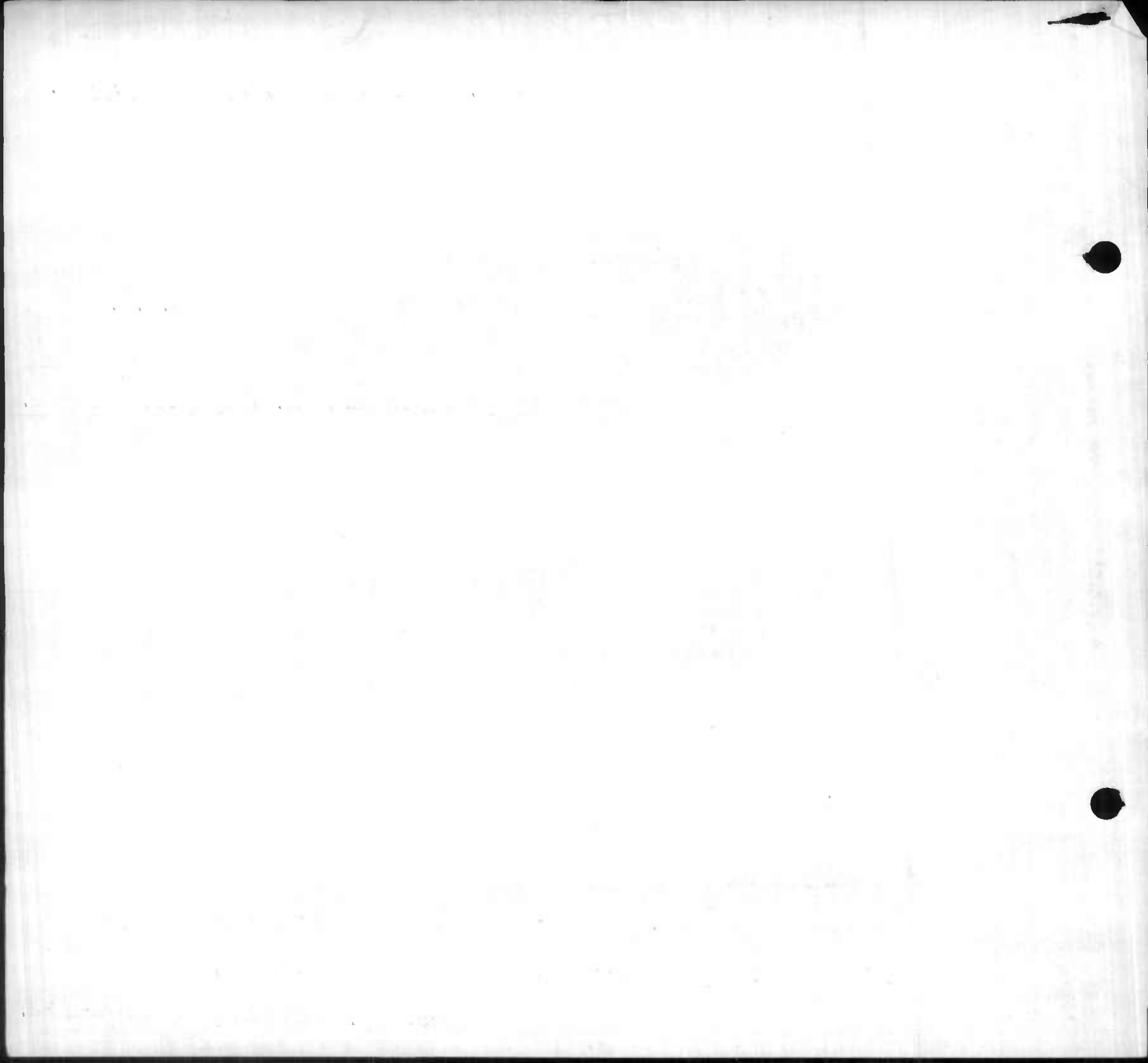
| BIRTH NO. 65 1396 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1396 | |
|---|---------|--|--|--|---------------------------------|--|--|----------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| KATHERINE LEARY POIRIER | | | | FEBRUARY 7, 1965 4:30 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| 5320 READY AVENUE | | | | MD. | | 27-10 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | BALTO. | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 5320 READY AVE. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| FEMALE | WHITE | WIDOWED | | May 10, 1878 | 86 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSEWIFE | | | | | | IRELAND | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| UNKNOWN | | | | UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | 213367911 | | MR. JOSEPH A. POIRIER | | SAME | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Arteriosclerotic Cardio-vascular Disease with Angina Pectoris | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | | | |
| | | | | (B) DUE TO | | | | | |
| | | | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 1950 to Feb. 1965, that (I) (we) last saw the deceased alive on 13 Jan. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Com. H. Kammer, Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/8/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr. | | | | 23D. ADDRESS 6011 York Rd. Balt. Md 21212 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| BURIAL | | 2/10/65 | | DULANEY VALLEY MEMORIAL | | BALTIMORE, MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | | | | | LEONARD J. RUCK, INC., BALTO., MD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

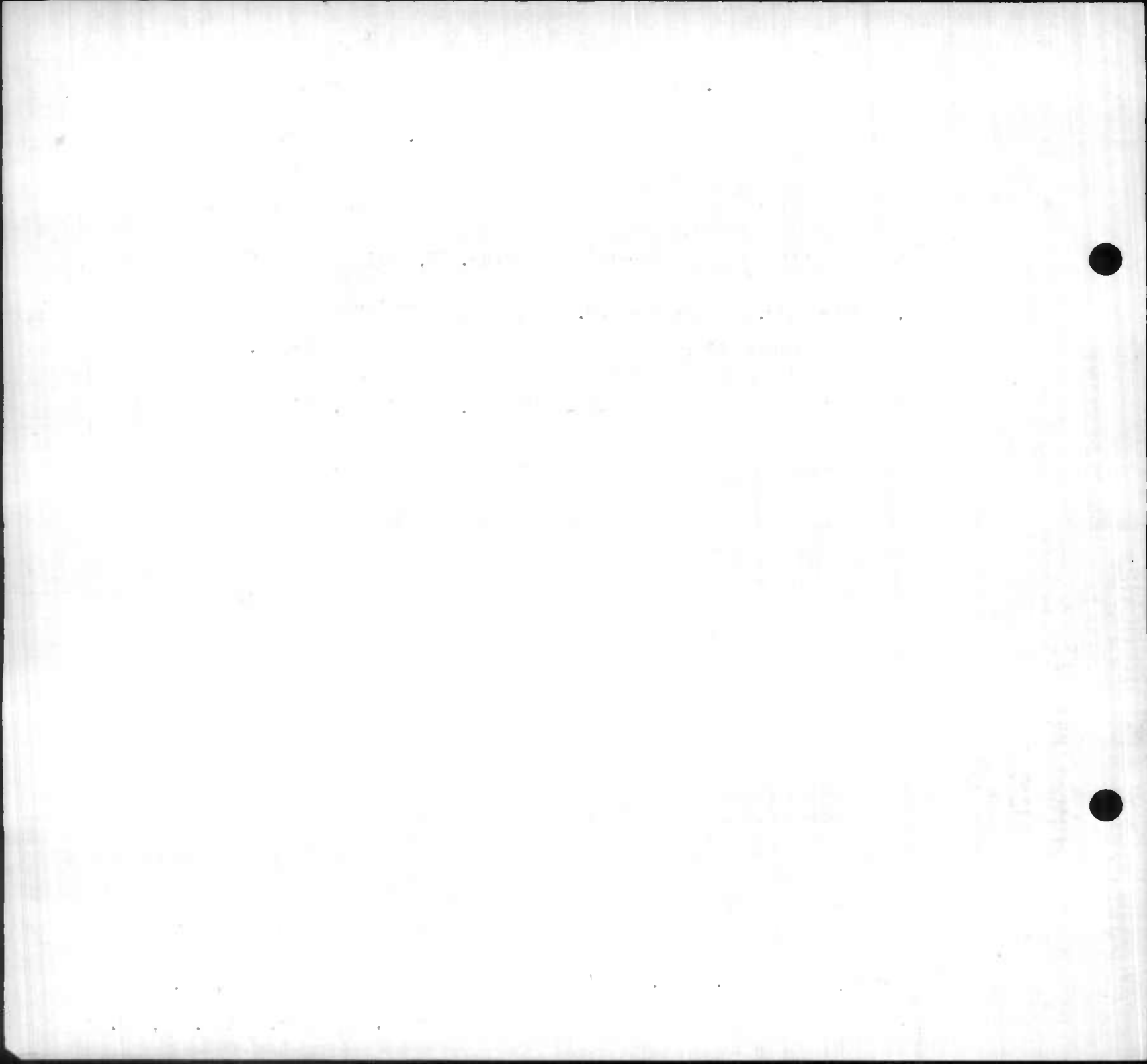
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1397 | |
|--|---------------------|--|--|---|--|--|--|---|---|--|--|
| BIRTH NO. 65 1397 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) TAYLOR, ELIZABETH M. | | | | | | 2. DATE AND HOUR OF DEATH February 6, 1965 5:55 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE md B. COUNTY 27-07 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH Home & Hospital | | | | | | C. CITY OR TOWN (If outside city limits, write 'RURAL' and give township) BALTIMORE | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 2930 BURWICK AVE | | | | | |
| 5. SEX F | 6. RACE w | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | | 8. DATE OF BIRTH 5-21-96 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) md | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph Brown | | | | | | 14. MOTHER'S MAIDEN NAME CLARA Reid | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Edward Taylor, Jr. | | | ADDRESS 1725 Glen Ridge Rd. | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial infarction | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6 19 65 to 2-6 19 65 , that (I) (we) last saw the deceased alive on 2-6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Ephraim Barzaga M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-6-65 | |
| 23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA M.D. | | | | | | | | 23D. ADDRESS CHURCH Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 2/10/65 | | | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc | | | |
| | | | | | | | | ADDRESS 5305 Harford Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

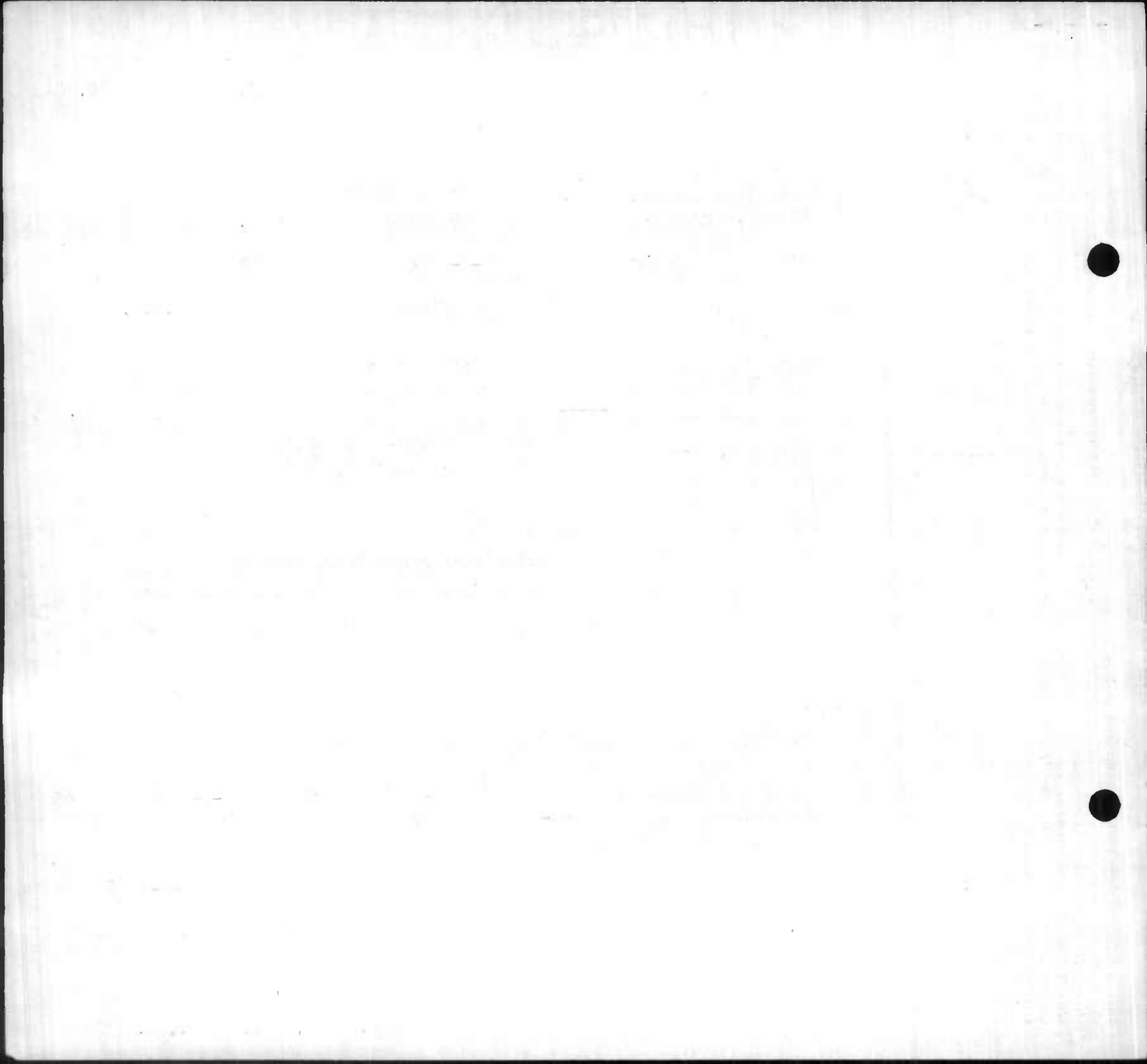
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1398 | |
|--|--|-------------------------|--|--|--|---|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 1398 CERTIFICATE OF DEATH X </div> | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>MILTON J. OHLER</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>2/5/65</u> <u>3:15</u> P. M. </div> </div> | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSPITAL</u> | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #34</u> D. STREET ADDRESS (If rural, give location) <u>9922 Harford Road</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>Aug. 27, 1911</u> | | 9. AGE (In years last birthday) <u>53</u> | | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Service Mgr.</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Koppers Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Ohler</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Callahan</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>215-07-5088</u> | | 17. INFORMANT <u>Mrs. Caroline M. Ohler</u> | | | | ADDRESS <u>(Same)</u> | |
| 18. <u>430.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u> <u>Pulmonary embolism</u> <u>ASCVD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2</u> 19 <u>65</u> to <u>Feb. 5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Gerardo Ypil Jr.</u> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>2/5/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>GERARDO YPIL JR.</u> | | | | | | 23D. ADDRESS <u>SINAI HOSPITAL</u> | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>2/9/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u> | | | | 24D. LOCATION (City, town, or county) (State) <u>Long Green, Md.</u> | |
| 25A. DATE RECEIVED BY FUNERAL DIRECTOR <u>FEB 8 1965</u> | | | | | | 25B. NAME OF REGISTRAR <u>Walter E. Farber, M.D.</u> | | | | 25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. 14, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

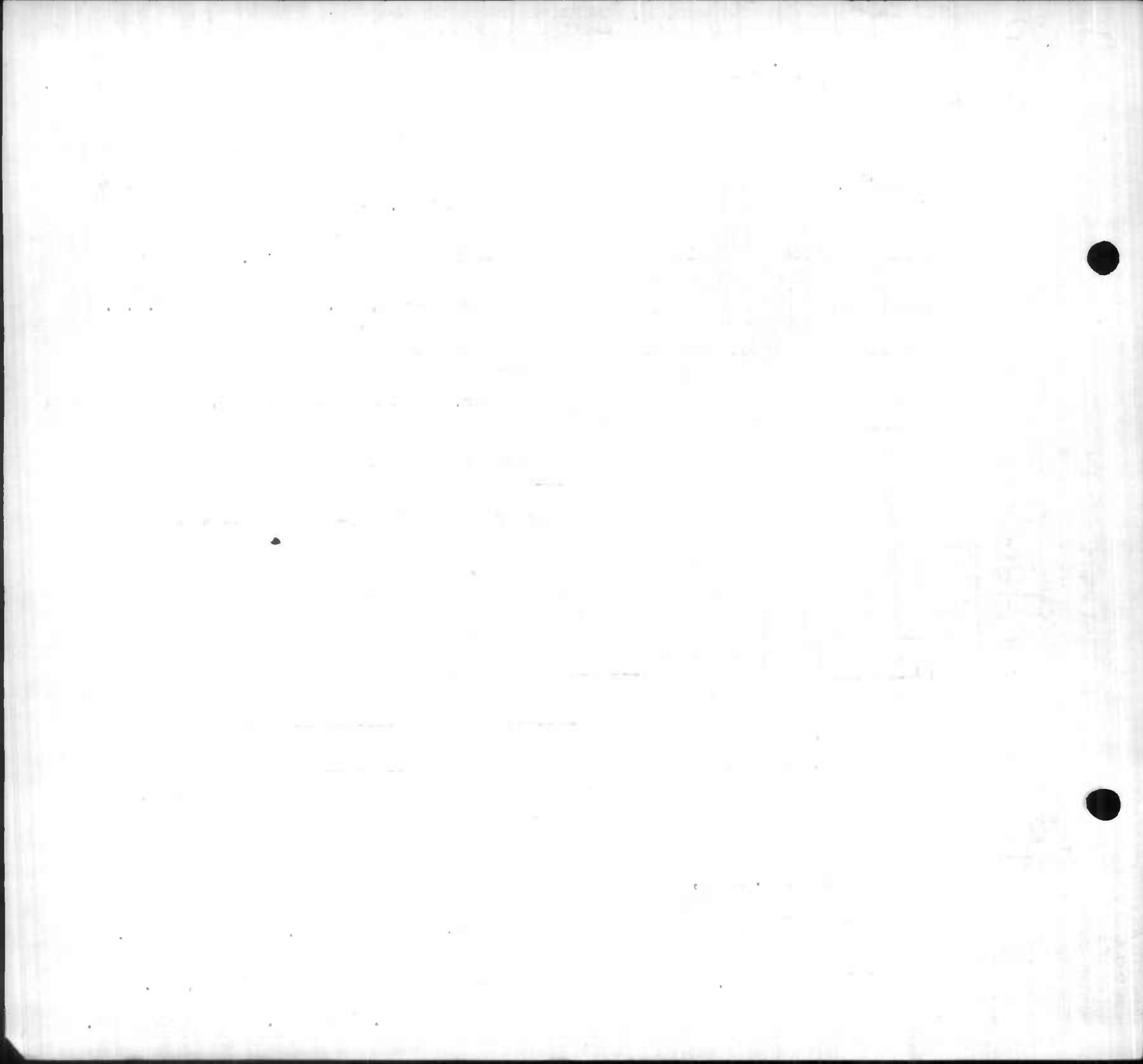
| | | | | | | | |
|---|-------------------------|---|-------------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. | | 65 1399 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1399 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Wilhelmina Wilson | | | | February 4, 1965 10:20A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland-21224 | | | | A. STATE Maryland B. COUNTY 8-86 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1529 North Wolfe Street, 21213 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 9-7-1874 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Wilson | | | | 14. MOTHER'S MAIDEN NAME Joann McShane | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease, Myocardial Infarction, Congestive Heart Failure | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO (B) DUE TO (C) Arteriosclerotic Heart Disease | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Pneumonia, Chronic Renal Disease | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-2- 19 65 to 2-4- 19 65 , that (I) (we) last saw the deceased alive on 2-4- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Cooke | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-4-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Cooke | | | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

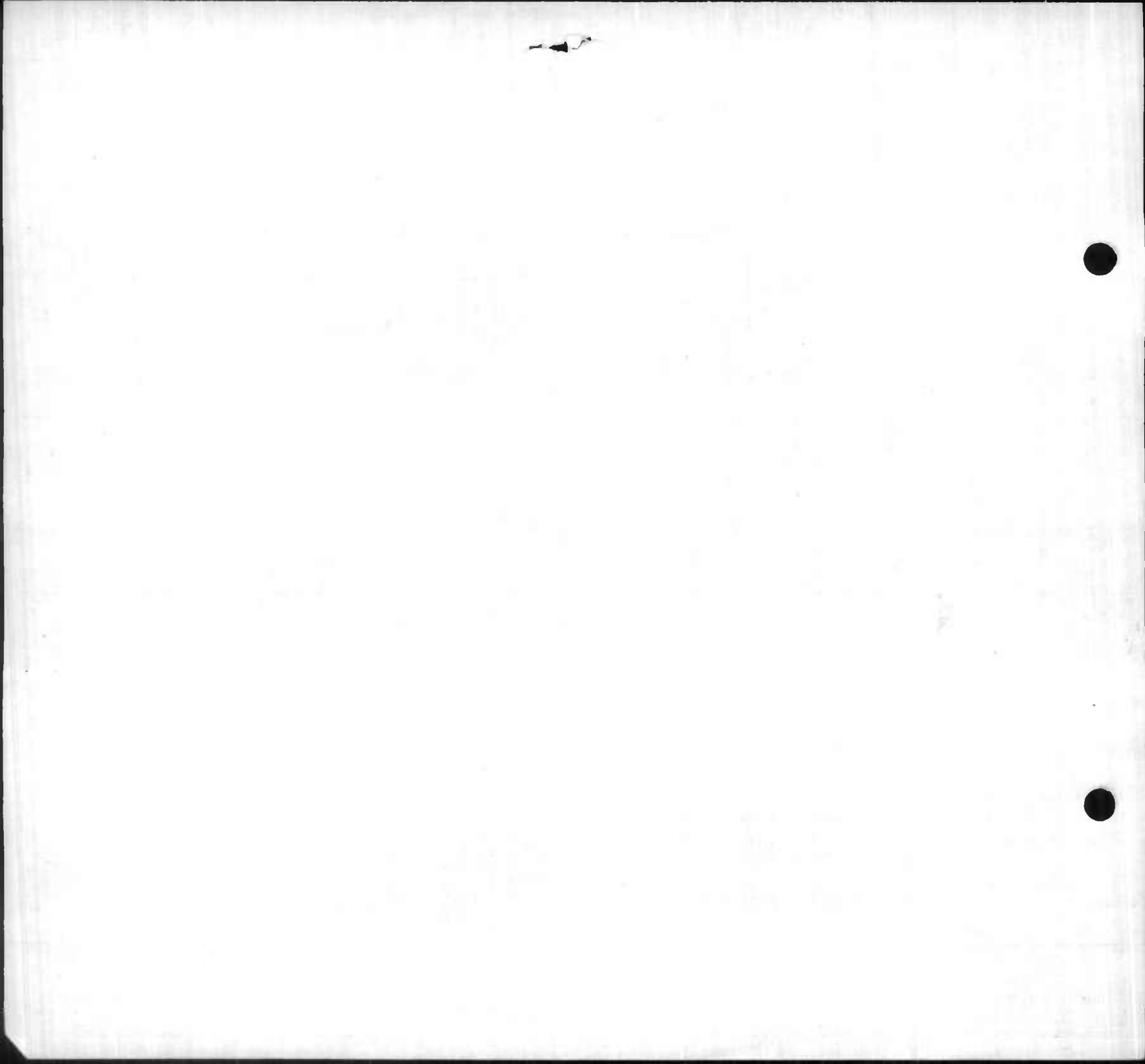
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 1400 | |
|---|--|-----------------------------|--|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 65 1400 | | M.E. CASE NO. M. | | 1. NAME OF DECEASED (Type or Print) Lena Gritz | | | | 2. DATE AND HOUR OF DEATH February 5, 1965 11:30 a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2920 E. Goldspring Lane | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2702 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2920 E. Goldspring Lane | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED Widowed | | 8. DATE OF BIRTH 12/18/74 | | 9. AGE (In years last birthday) 90 Yrs. | | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown Last name Dietz | | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mr. William Gritz 2920 E. Goldspring Lane | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 491X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Broncho pneumonia DUE TO Hypertensive cardio-vascular disease DUE TO Old Age | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days About 15 Yrs | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Old Age | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0 | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0 | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0 | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? 0 | | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 1949 to February 5, 1965 , that (I) (we) last saw the deceased alive on February 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE ERNEST G. MARR, M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | 23B. DATE SIGNED 2/5/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Ernest G. Marr | | | | | | 23D. ADDRESS M.D. 516 Cathedral St., Baltimore, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/9/65. | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1401 | |
|---|---------------------|---|--|--|--|
| BIRTH NO. 65 1401 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) O'DONNELL, Mr. JOHN A. | | 2. DATE AND HOUR OF DEATH Feb. 5, 65 4:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lutherville 53-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1612 Greenspring Dr. | | |
| 5. SEX M | 6. RACE W | 7. <input checked="" type="radio"/> MARRIED, NEVER MARRIED <input type="radio"/> WIDOWED, <input type="radio"/> DIVORCED (specify) M | | 8. DATE OF BIRTH 8-3-89 | 9. AGE (in years last birthday) 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Crown Cork & Seal | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md | |
| 13. FATHER'S NAME JOHN H. O'Donnell | | | 14. MOTHER'S MAIDEN NAME Annie (Develin) Develin | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-01-0530 | | 17. INFORMANT Patient | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH Cerebrovascular accident prob. arterio sclerotic thrombosis ① hemorrhage. | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-27 19 65 to 2-5 19 65 , that (I) (we) last saw the deceased alive on 4:00 AM, 2-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jooy Hyun Sohn M.D. | | | | 23B. DATE SIGNED Feb 5, '65 | |
| 23C. PHYSICIAN'S NAME (Type) Jooy Hyun Sohn M.D. | | | | 23D. ADDRESS Maryland General Hospital | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE 2-8-65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE - MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR Leonard J. Hook Inc | |
| | | | | ADDRESS 5305 Hayford | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 65 1402 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1402 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Daniel B. Fager</i> | | | | | 2. DATE AND HOUR OF DEATH <i>February 4, 1965 6:30 A.M.</i> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 2-18-65 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Harford Gardens</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-07</i> | | | | | | | | | |
| 5. SEX MALE | | | | | 6. RACE WHITE | | | | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR BUILDER | | | | | 10B. KIND OF BUSINESS OR INDUSTRY B & O R R | | | | | 8. DATE OF BIRTH SEPT. 13, 1883 81 | | | | |
| 13. FATHER'S NAME JOSEPH FAGER | | | | | 14. MOTHER'S MAIDEN NAME MARGARET TATUM | | | | | 9. AGE (In years last birthday) 81 | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <i>(2)</i> 705-03-5121 | | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | |
| 18. <i>334 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) <i>Cerebral Arteriosclerosis</i> DUE TO (B) <i>Generalized Arteriosclerosis</i> DUE TO (C) _____ | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> <i>Indef.</i> | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5 Mar 1955</i> to <i>4th 3 Feb 65</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>30 Jan 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23B. DATE SIGNED <i>4th 3 Feb 65</i> | | | | |
| 23A. SIGNATURE <i>John B. DeHoff</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23D. ADDRESS M.D. <i>1701 Meridene Drive - Balto. 12, Md.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE <i>2/8/65</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY | | | | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | | | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i> | | | | |
| 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | | | | 25D. ADDRESS <i>5305 Harford Rd.</i> | | | | | | | | | |

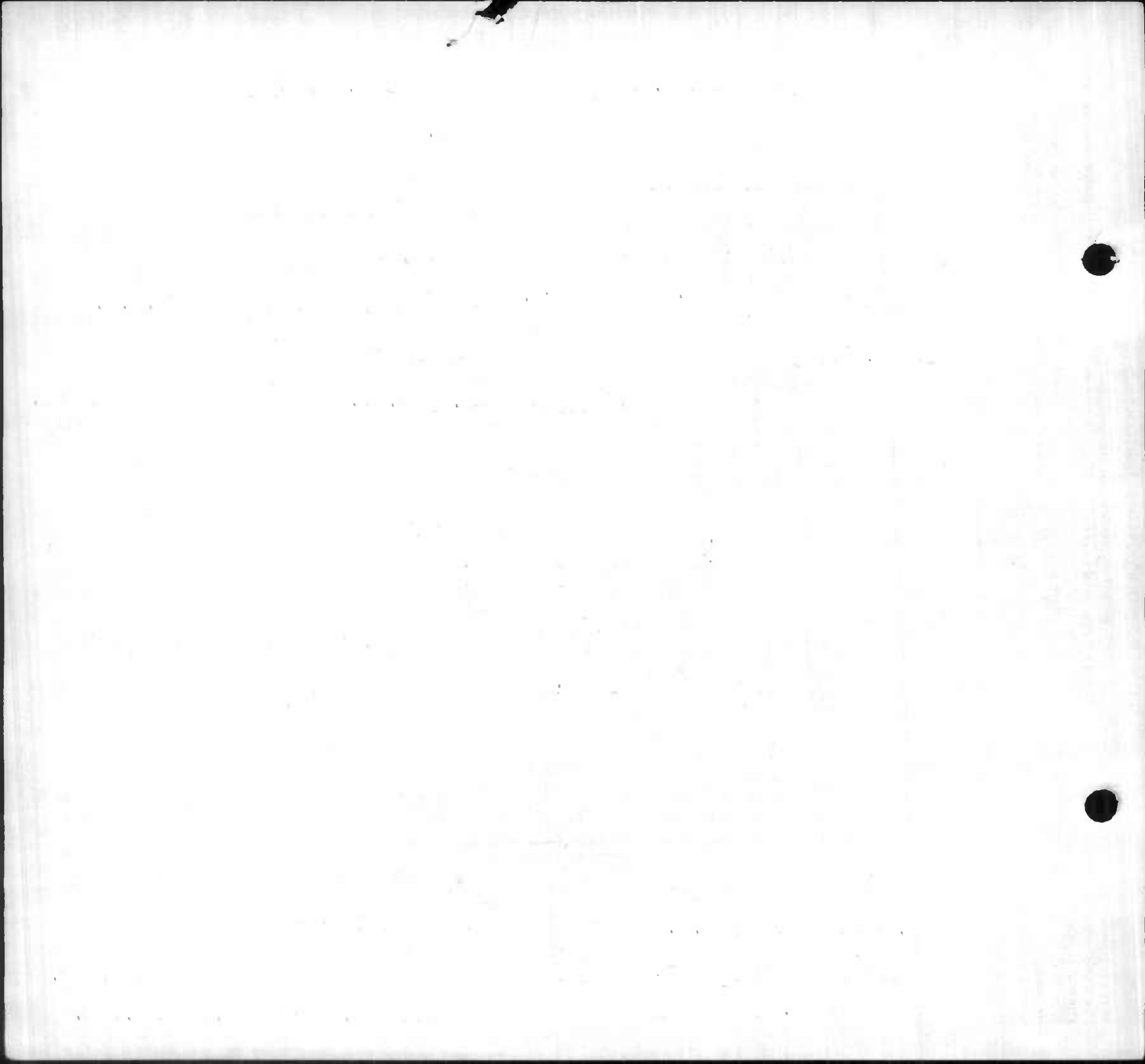
Letter from Dr. John B. DeHoff
2-18-65

M.H.

(Handwritten signature)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------|--|---|--|--|
| 65 1403 | | X | | 65 1403 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Elizabeth M. Pfaff | | Feb. 2, 1965 | | 8 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Melchor Nursing Home | | | Md. Baltimore | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | 53-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 8305 Avondale Road | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Female | White | Widow | July 16, 1885 | 79 | Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Baltimore, Maryland | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Frederick Ey | | | Mary Freiwald | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 212099581 | | Lt. Geo. T. Pfaff 4365 Sheldon Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| 422.1 4170 X | | | (A) Chronic myocarditis | | 2 mo. |
| ANTECEDENT CAUSES | | | (B) Atherosclerosis | | 2 yrs. |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Carcinoma of heart lvs | | 19 yrs. |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 11-47 | | Ca of heart | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1947 to 2-2-1965, that (I) (we) last saw the deceased alive on 2-1-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Duer Moores | | | | 2-4-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| J. Duer Moores, M.D. | | | 3105 Belair Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/6/65 | | First United Evangelical Church Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 8 1965 | | Robert E. Fisher, M.D. | | Leonard J. Ruck, Inc., Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1404 | |
|---|---|---|---|--|---|
| BIRTH NO. 65 1404 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) JOHNSON - JONAS - George | | | 2. DATE AND HOUR OF DEATH 2-7-65 9:15 AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Luthers Hospital of Maryland | | | A. STATE MD B. COUNTY 27-13 | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 6001 Hunt Club Rd | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED/NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH May 13, 1894 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Readybuilt Prod. Co. | | | 11. BIRTHPLACE (State or foreign country) Chicago, Illinois | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Alfred Johnson | | | 14. MOTHER'S MAIDEN NAME Anna Johnson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 216-05-3434 | 17. INFORMANT Mrs. Christine Johnson ADDRESS same | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO myocardial infarction (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1-31-65 7 2-7-65 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-31-1965 to 2-7-1965 , that (I) (we) last saw the deceased alive on 2-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Siroos M.D. | | | | 23B. DATE SIGNED 2-7-65 | |
| 23C. PHYSICIAN'S NAME (Type) SIROOS GERAMI | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/10/65 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd. | |

George Washington

Dear Sir

I have the honor to acknowledge

the receipt of your letter

of the 10th inst.

in relation to

the matter of the

7th Decr 1793

Yrs

Wm. M. Smith

per Mr. R.

1

65 1405

BALTIMORE CITY HEALTH DEPARTMENT

65 1405

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS DRINKS

2. DATE AND HOUR PRONOUNCED DEAD

February 7, 1965 4:15a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

6116 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6116 Belair Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

June 14, 1876

9. AGE (In years
last birthday)

88

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret. (Credit Manager)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul Drinks

14. MOTHER'S MAIDEN NAME

Louise

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Edwin L. Drinks, 9107 Smith Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-7-6523A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

2/10/65

Parkwood Cemetery

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

Leonard J. Ruck Inc 5305 Harford Rd.

WALLACE POLICE

PAGE 1

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

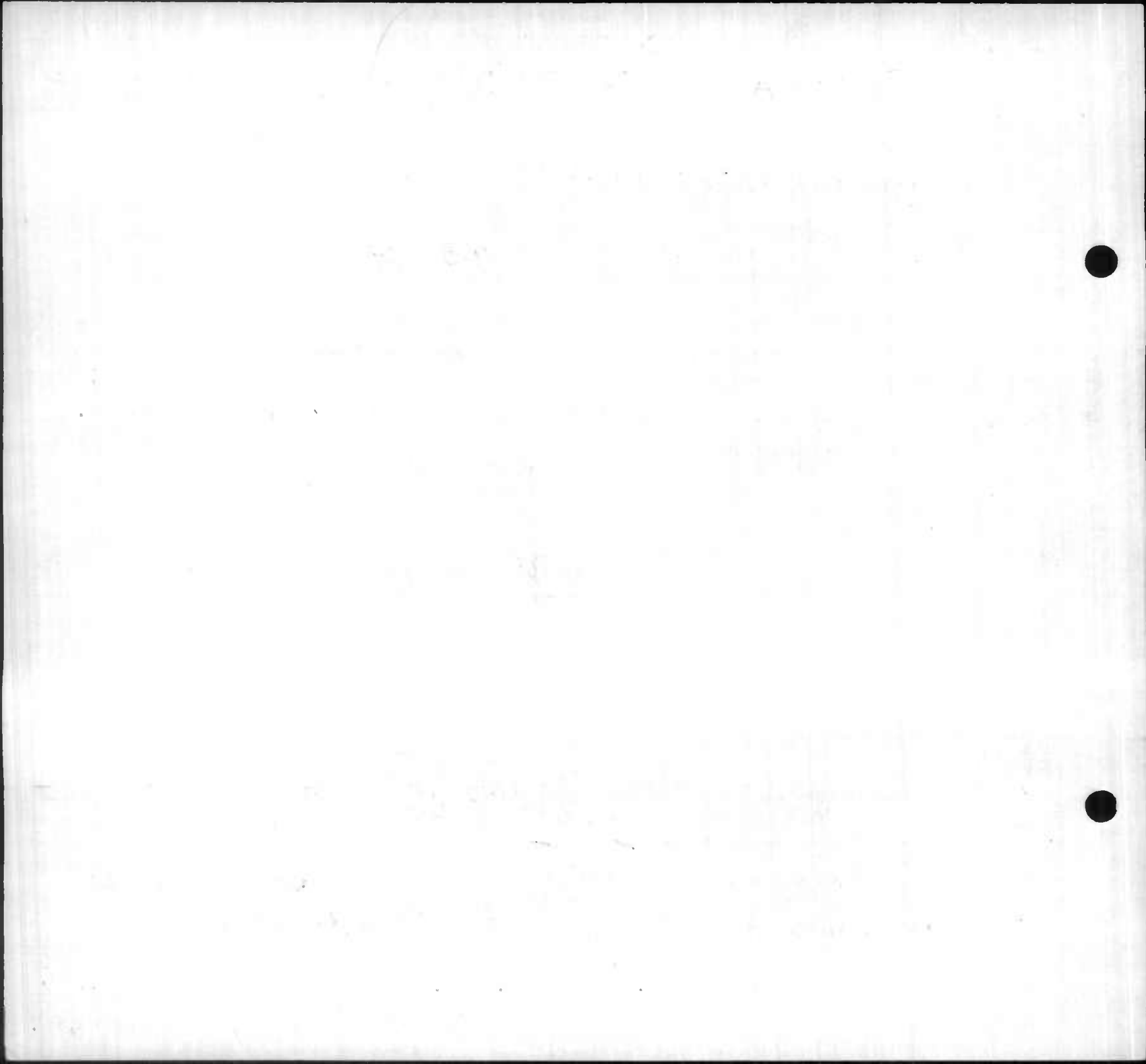
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1406 | |
|---|-------------------------|---|-----------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65-04659 1406 | | M.E. CASE NO. William Albert Mangels, Jr. | | | |
| 1. NAME OF DECEASED (Type or Print) MANGELS, Baby Boy | | 2. DATE AND HOUR OF DEATH 2/6/65 8.45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-06 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto, Md | | | |
| | | D. STREET ADDRESS (If rural, give location) 2904 White Ave | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 2/4/65 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto, Md | |
| 13. FATHER'S NAME William A. Mangels Sr. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MR. William A. Mangels, Sr. SAME | |
| 18. 763.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Bilateral Pulmonary Congestive Extensive Neonatal Prematurity (B) Due to (C) Prematurity | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/4/65 19 to 2/6/65 19, that (I) (we) last saw the deceased alive on 2/6/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Antoine Arrage | | | | 23B. DATE SIGNED 2/8/65 | |
| 23C. PHYSICIAN'S NAME (Type) ANTOINE ARRAGE | | | | 23D. ADDRESS Church Home & Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY ST. THOMAS CEM. | |
| | | | | 24D. LOCATION (City, town, or county) (State) GARRISON FOREST, MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS LEONARD J RUCK INC. HARTFORD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

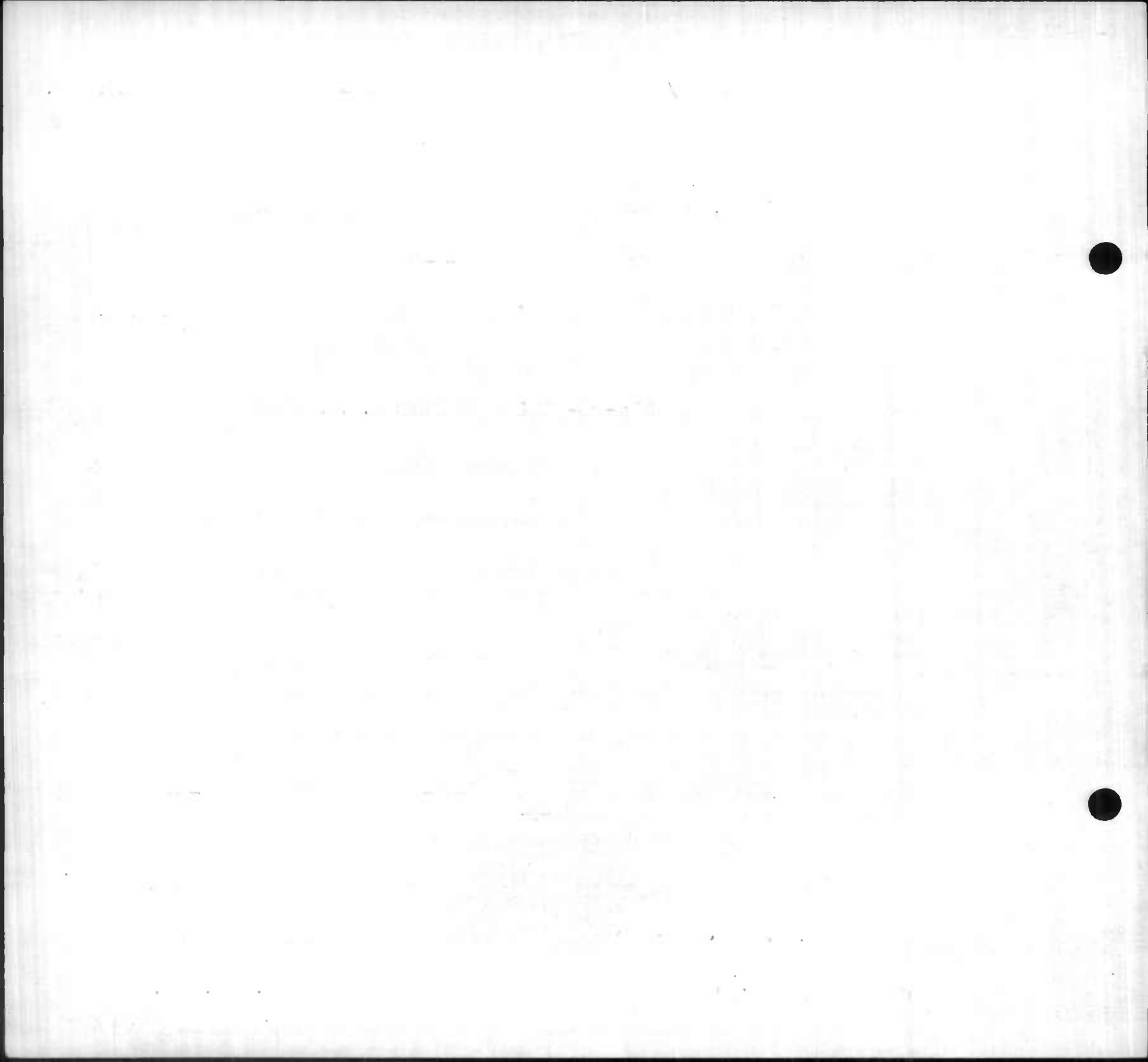
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------|--|---|--|--|--|----------------------------------|--|--|
| X CERTIFICATE OF DEATH | | | | | Registered No. 65 1407 | | | | |
| BIRTH NO. 65 1407 | | | | | 2. DATE AND HOUR OF DEATH 2-3-65 440 P.M. | | | | |
| 1. NAME OF DECEASED (Type or Print) BERTHA V. STRAWBRIDGE | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 CENTURY CONVAL. HOME | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pylesville 62-00 | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9-9-1884 | 9. AGE (in years last birthday) 80 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME George Harrison | | | | | 14. MOTHER'S MAIDEN NAME Jane Hitchcock | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Harry Strawbridge, Pylesville, Md. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardio - Respiratory Failure DUE TO Congestive Heart Failure (B) Arteriosclerosis, CVA DUE TO Parkinson's Disease (C) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from NOV 11 1963 to FEB 3 1965, that (I) (we) last saw the deceased alive on FEB 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Willard Applefeld M.D. | | | | | 23B. DATE SIGNED 2/3/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Willard Applefeld M.D. | | | | | 23D. ADDRESS 5901 Park Heights Av. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Feb. 6, 65 | | 24C. NAME OF CEMETERY or CREMATORY St. Paul Meth. Cem. | | 24D. LOCATION (City, town, or county) (State) Pylesville, Harford Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Kenneth W. Quiburn, Stewartstown, Pa. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

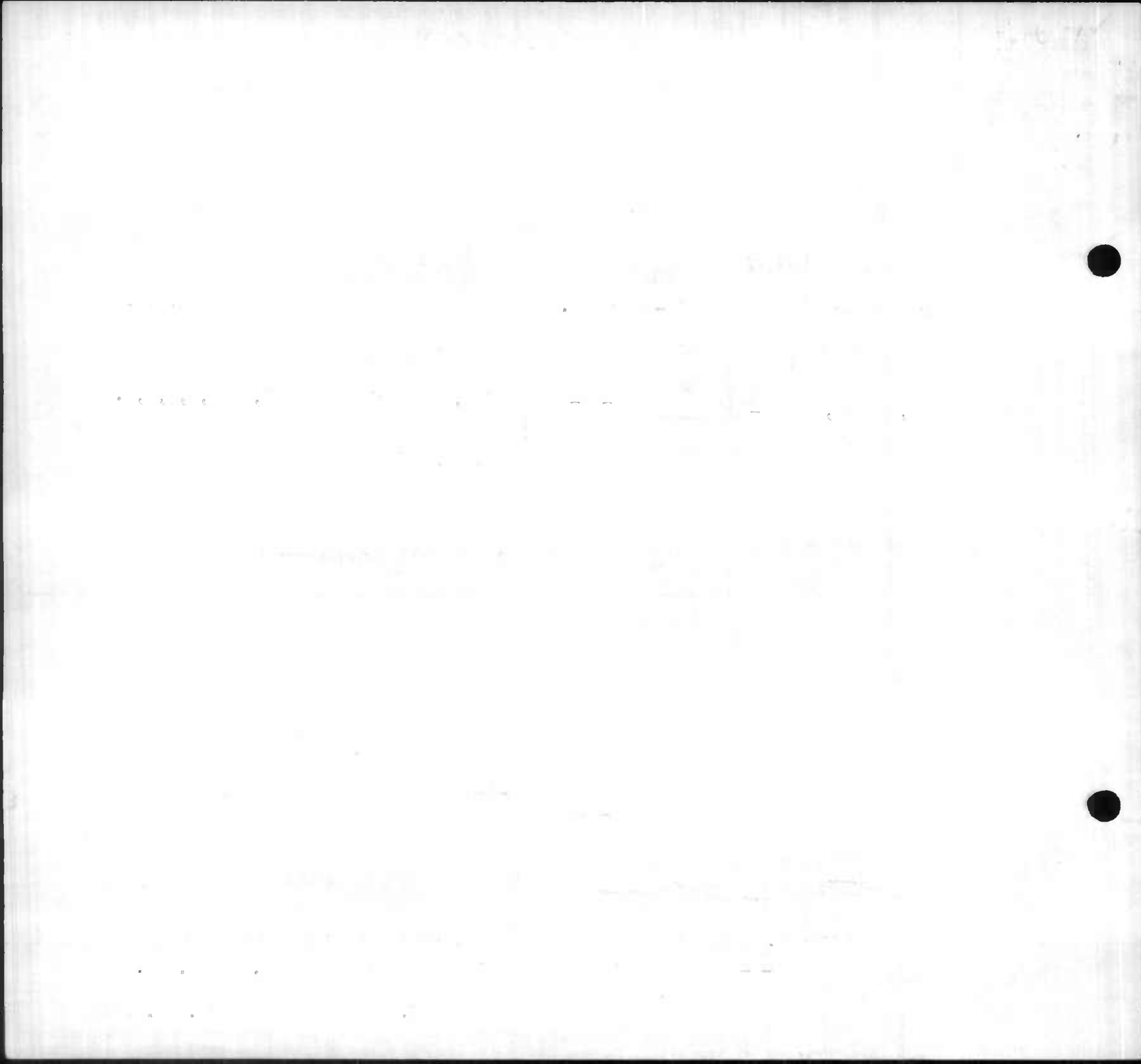
| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 65 | | 1408 | | 1408 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) OLIVER Joseph/Magee | | | | 2. DATE AND HOUR OF DEATH 2-3-65 11:50 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-6-36 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 1723 South Rappolla Street | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY GENERAL CONSTR. | | 8. DATE OF BIRTH 11-7-90 | |
| | | | | 9. AGE (In years last birthday) 74 | |
| 13. FATHER'S NAME ROBERT J. MAGEE | | 14. MOTHER'S MAIDEN NAME MARY ROBERTS | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-03-3342 | | 17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH 48 Hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-12-19 65 to 2-3-19 65, that (I) (we) last saw the deceased alive on 2-3-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. M. Schuster | | | | 23B. DATE SIGNED 2-3-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. M. Schuster | | | | 23D. ADDRESS 4940 Eastern Avenue #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE Feb. 8, 65 | | 24C. NAME OF CEMETERY or CREMATORY OAKLAWN | |
| 25A. DATE RECEIVED BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS WALTER BRIDGES BRADLEY, JR. HENDERSON, MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1409 | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. 65 1409 | | | | X CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Calvin McFaul | | | | 1:00 PM 2-4-65 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | | A. STATE Maryland B. COUNTY Baltimore | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 205 S. Woodwell Rd. | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/22/14 | 9. AGE (In years last birthday) 50 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wire drawer | | 10B. KIND OF BUSINESS OR INDUSTRY Reid-Avery Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME William Mc Faul | | | 14. MOTHER'S MAIDEN NAME JULIA Benton | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes, Navy, 1940-1942 | | | 16. SOCIAL SECURITY NO. 214-05-3975 | | |
| | | | 17. INFORMANT ADDRESS Wife, Katherine Mc Faul, # 4,a,b,c,d. | | |
| 18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gastrointestinal Hemorrhage with shock | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal Cell Adenocarcinoma | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-1-65 19 to 2-4-65 19, that (I) (we) last saw the deceased alive on 2-4-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Steve L. Johnson | | | | 23B. DATE SIGNED 2-4-65 | |
| 23C. PHYSICIAN'S NAME (Type) Steve L. Johnson | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-8-1965 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| | | | | 24D. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Md. 21222 | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY E. OUTERBRIDGE

2. DATE AND HOUR PRONOUNCED DEAD

February 5, 1965 5:50 p

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

8024 N. Boundary Road

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

Dec. 20, 1889

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Elmore

14. MOTHER'S MAIDEN NAME

Margaret Andrews

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

No

17. INFORMANT

ADDRESS

Son, Douglas Outerbridge, 1933 Penhall Rd. 22
Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

8024 N. Boundary Road

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

2 4 65 6:00a

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell down stairs at home

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-6-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-10-1965

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

(State)

Eastern Ave. Bal. Co. Md. 21222

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

John J. Duda 7922 Wise Ave. Dundalk, Md.

WALL EVIDENCE

1

65 1411

BALTIMORE CITY HEALTH DEPARTMENT

65 1411

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GORDON FORREST

2. DATE AND HOUR PRONOUNCED DEAD

2/5/65

4:23 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore
City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2816 Wells Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 16, 1916

9. AGE (In years
day)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Heater in coke div.

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Floyd Forrest

14. MOTHER'S MAIDEN NAME

Rosamond Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.
213-09-8226

17. INFORMANT

ADDRESS

Wife, Oneta Forrest, #4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

W.U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

2/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-9-1965

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial

23D. LOCATION

(City, town, or county)

(State)

Washington Blvd. Dorsey, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Md. 21222

ADDRESS

WATLEY POLICE

ALPHABETICALLY

.....

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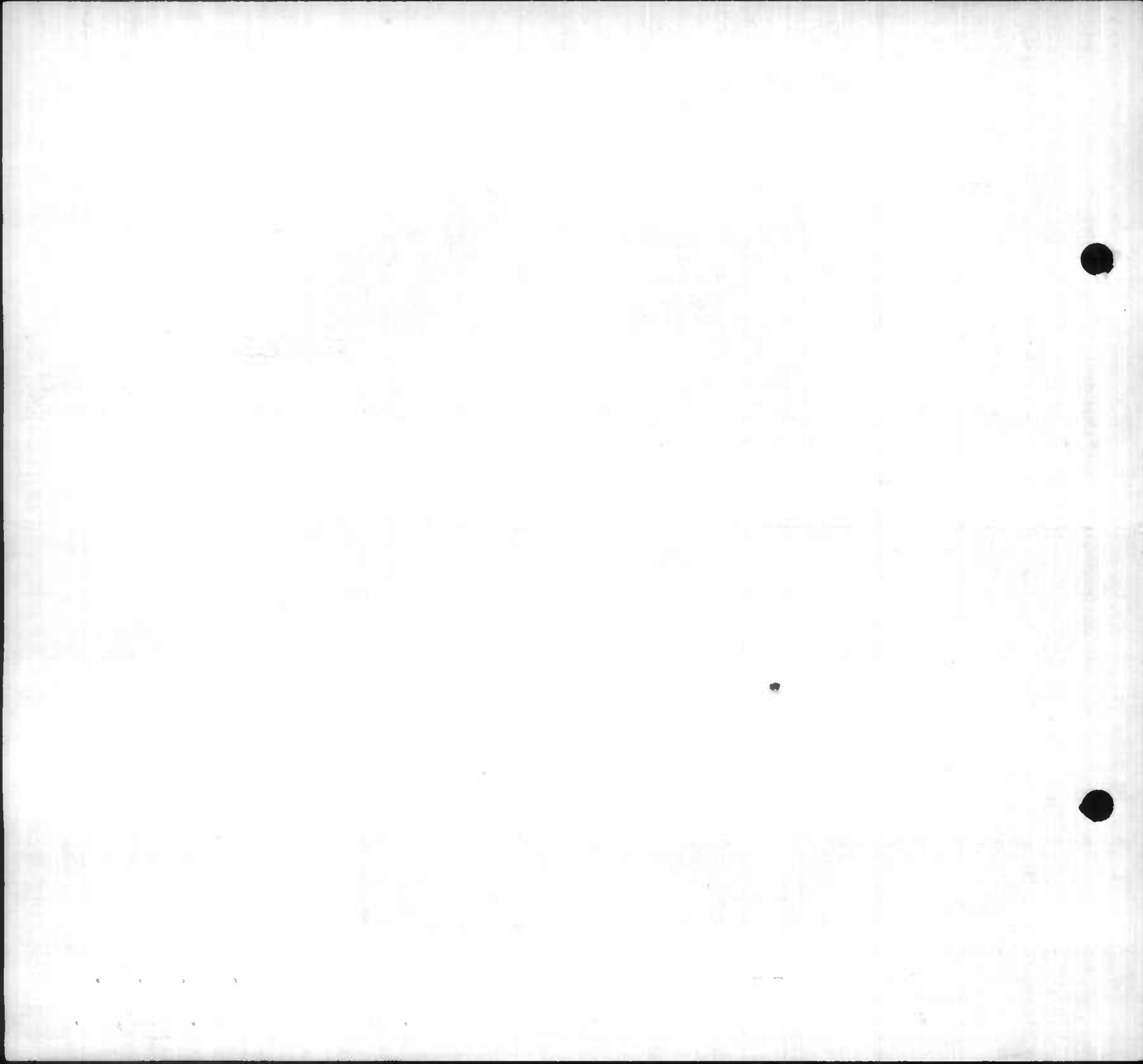
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

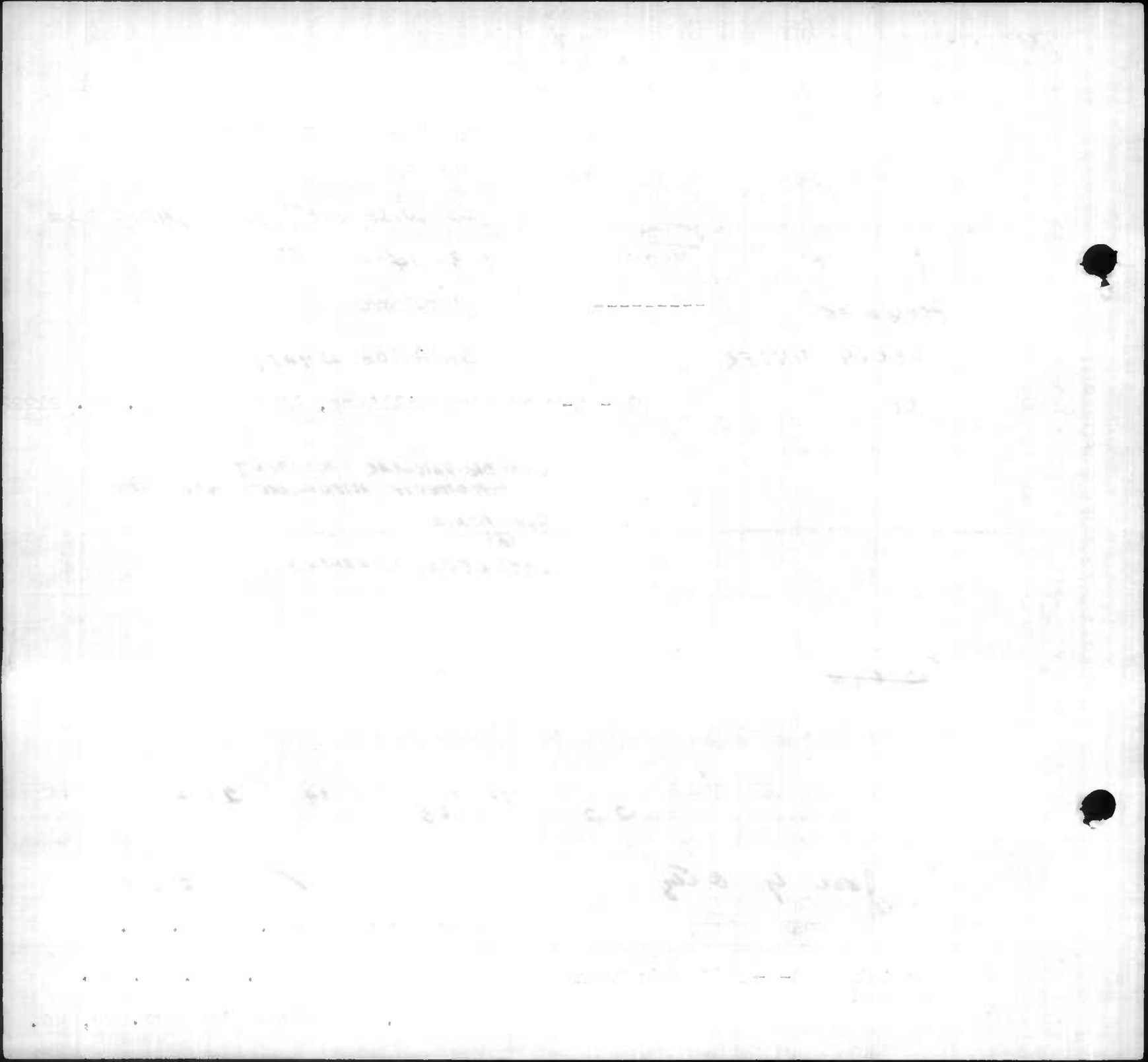
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1412 | |
|--|-------------------------|--|--|--|--|--|--|
| BIRTH NO. 65 1412 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) GEORGE D. GRIFFITHS | | 2. DATE AND HOUR OF DEATH February 5, 1965 8:15 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | A. STATE Maryland B. COUNTY Baltimore | | | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - Dundack | | | | | |
| | | D. STREET ADDRESS (If rural, give location) 2957 Cornwall Road 53-00 | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Feb. 11, 1903 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labore. | | 10B. KIND OF BUSINESS OR INDUSTRY Listkeyalum Co. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Griffiths | | 14. MOTHER'S MAIDEN NAME Lucy Tidball | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-01-4031 | | 17. INFORMANT Son, John Griffiths | | ADDRESS 1217 Breunig Hwy RA-74 | |
| 18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Brain tumor | | (A) DUE TO | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO CVA & respiratory + cardiac failure | | | | | |
| | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 26, 1965 to Feb 5, 1965 , that (I) (we) last saw the deceased alive on Feb 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Nieva G. Valle | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED February 5, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) NIEVA G. VALLE | | 23D. ADDRESS M.D. Maryland General Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-9-1965 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | | 24D. LOCATION (City, town, or county) (State) Trumps Mill Rd. Bal. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR John J. Duda | | ADDRESS 7922 Wise Ave. 21222, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

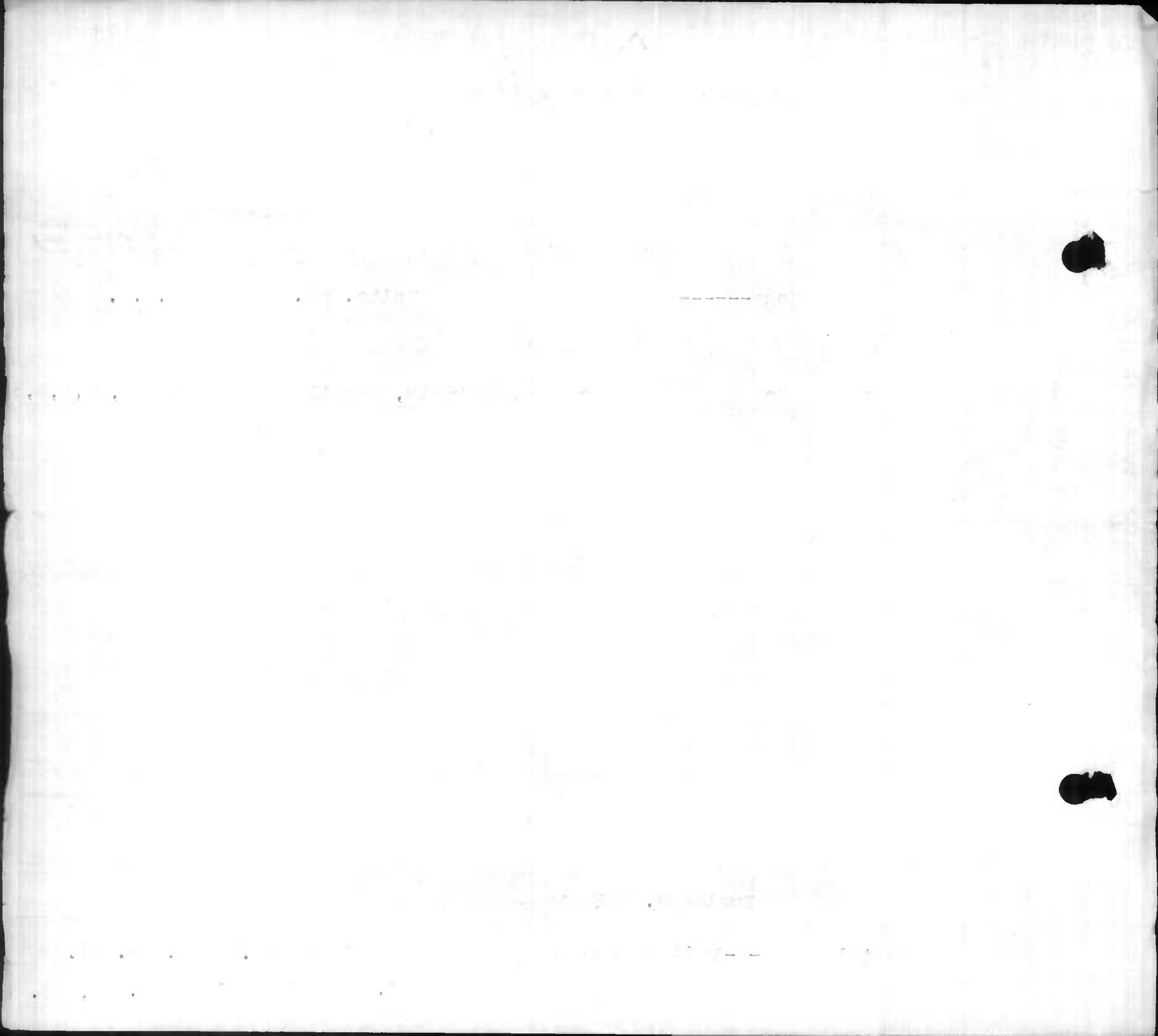
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1413 | |
|---|--------------|--|----------------------------|--|--|
| BIRTH NO. 65 1413 | | X | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CORNELIA HODGES | | 2. DATE AND HOUR OF DEATH 2-2-65 12:07 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL | | D. STREET ADDRESS (If rural, give location) 105 WISE AVE., BALTO., MD. 21222 | | 53-00 | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-3-14 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland U.S.A. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME HENRY MILLER | | 14. MOTHER'S MAIDEN NAME AMANDA WYATT | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. 212-22-7896 | | 17. INFORMATION Helen Williams, 1934 Barry Rd. Md. 21222 | | ADDRESS | |
| 18. 443X 5811 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) CEREBRO-VASCULAR ACCIDENT DUE TO HYPERTENSIVE ARTERIOCLEROTIC HEART DISEASE (B) PNEUMONIA DUE TO (A) (C) LAENNEC'S CIRRHOSIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-18-64 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-1-1964 to 2-2-1965, that (I) (we) last saw the deceased alive on 2-2-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jose Y Ortiz | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) JOSE ORTIZ | | 23D. ADDRESS M.D. Church Home & Hosp. Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-5-1965 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | |
| 24D. LOCATION (City, town, or county) (State) Eastern Ave. Bal. Co. Md. | | 24E. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR JOHN J. DUDA 7922 Wise Ave. 22, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1414 | |
|--|------------------|--|--|--|---|--|--|
| BIRTH NO. 64 34038 65 1414 X | | | | | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Paula Bolyard</i> | | | |
| 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 2. DATE AND HOUR OF DEATH <i>2-2-65 9⁵⁰ P.M.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balt.</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 22</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1721 Kirkland St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i> | | 8. DATE OF BIRTH <i>12-12-64</i> | 9. AGE (In years last birthday) <i>1 mos.</i> | If Under 1 Yr. Months: Days: <i>— 22 days</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | |
| 13. FATHER'S NAME <i>Denzil D. Bolyard</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Lora Jo. Martin</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>No</i> | | 17. INFORMANT ADDRESS <i>Parents, Denzil & Lora Bolyard, #4, a, b, c</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>7544 I</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) <i>Longest congenital heart disease</i> | | <i>since birth</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <i>fibrosclerosis</i> | | | |
| II | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>Pneumonia</i> | | <i>4 weeks</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (neatly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-4</i> 19 <i>65</i> to <i>2-2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>2-2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Imelda B. Salavio</i> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>2-3-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Imelda B. Salavio</i> M.D. | | | | 23D. ADDRESS <i>Mercy Hospital Balto. Md. 2120</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-4-1965</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn</i> | | 24D. LOCATION (City, town, or county) (State) <i>Eastern Ave. Bal. Co. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>JOHN J. DUDA 7922 Wise Ave. 22, Md.</i> | | | |



BIRTH NO. 65 1415

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1415

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. TRESCOTT JR.

2. DATE AND HOUR PRONOUNCED DEAD

2/4/65

10:35 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4298 Highview Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

5/9/15

9. AGE (In years
and birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SELF-EMP. SALES

10B. KIND OF BUSINESS OR INDUSTRY

LIQUOR STORE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM H. TRESCOTT, SR.

14. MOTHER'S MAIDEN NAME

BERTHA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.

212109934

17. INFORMANT

ADDRESS

RUTH K. TRESCOTT 4298 HIGHVIEW AVE. 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Bunshot wounds of chest with perforation
of pulmonary artery, aorta, right
atrium, left pulmonary vein, and lower lobes
of both lungs and extensive hemothorax

DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

store

21C. WHERE DID (If in Baltimore City, give exact location)

Little Brown Jug Liquor Store
4043 Wilkens Ave.21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

2 4 65 10:15p.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

subject was shot in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2/9/65

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY

23D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD 4107 WILKENS AVE. 21229

WALTON

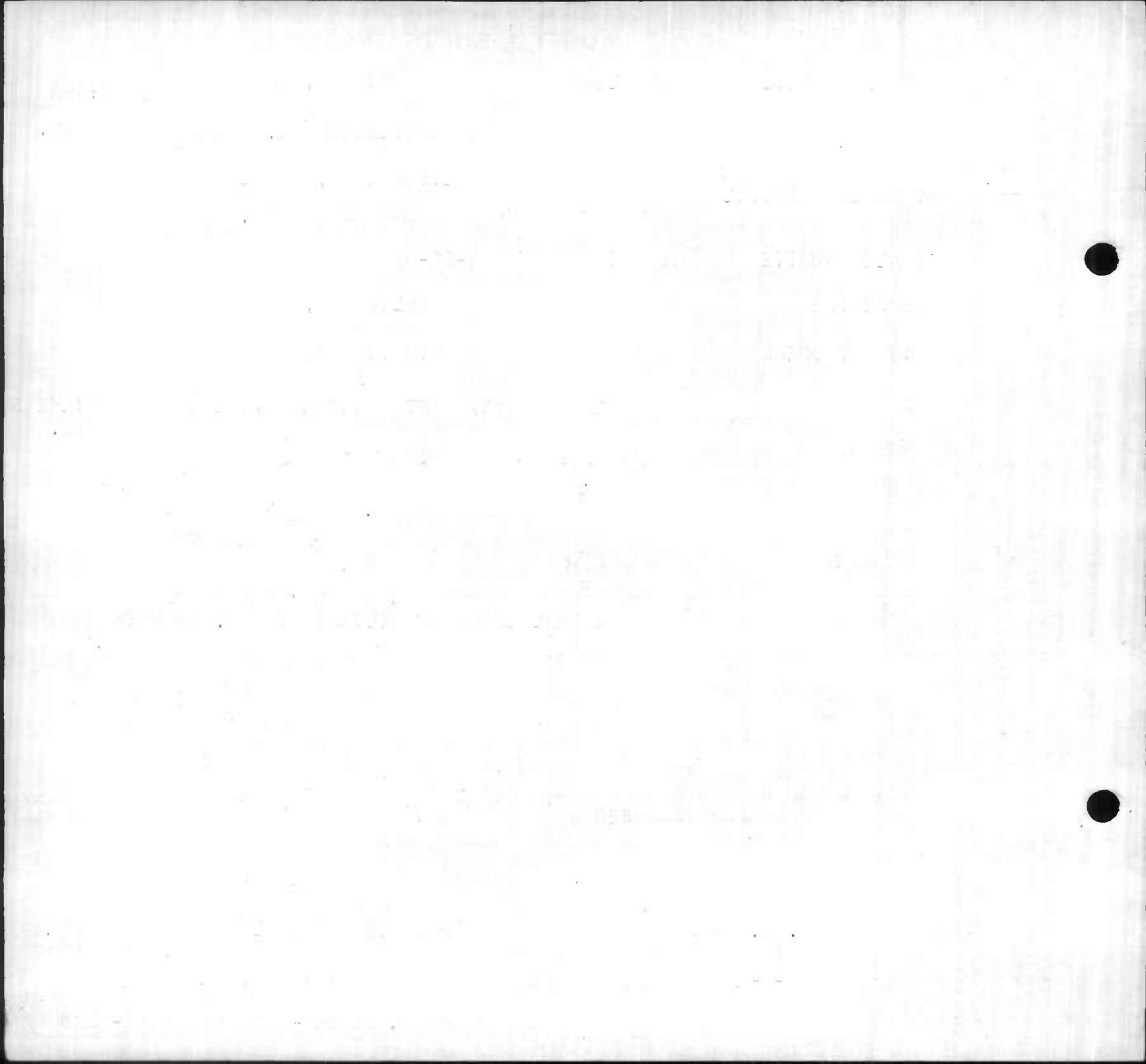
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1/2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

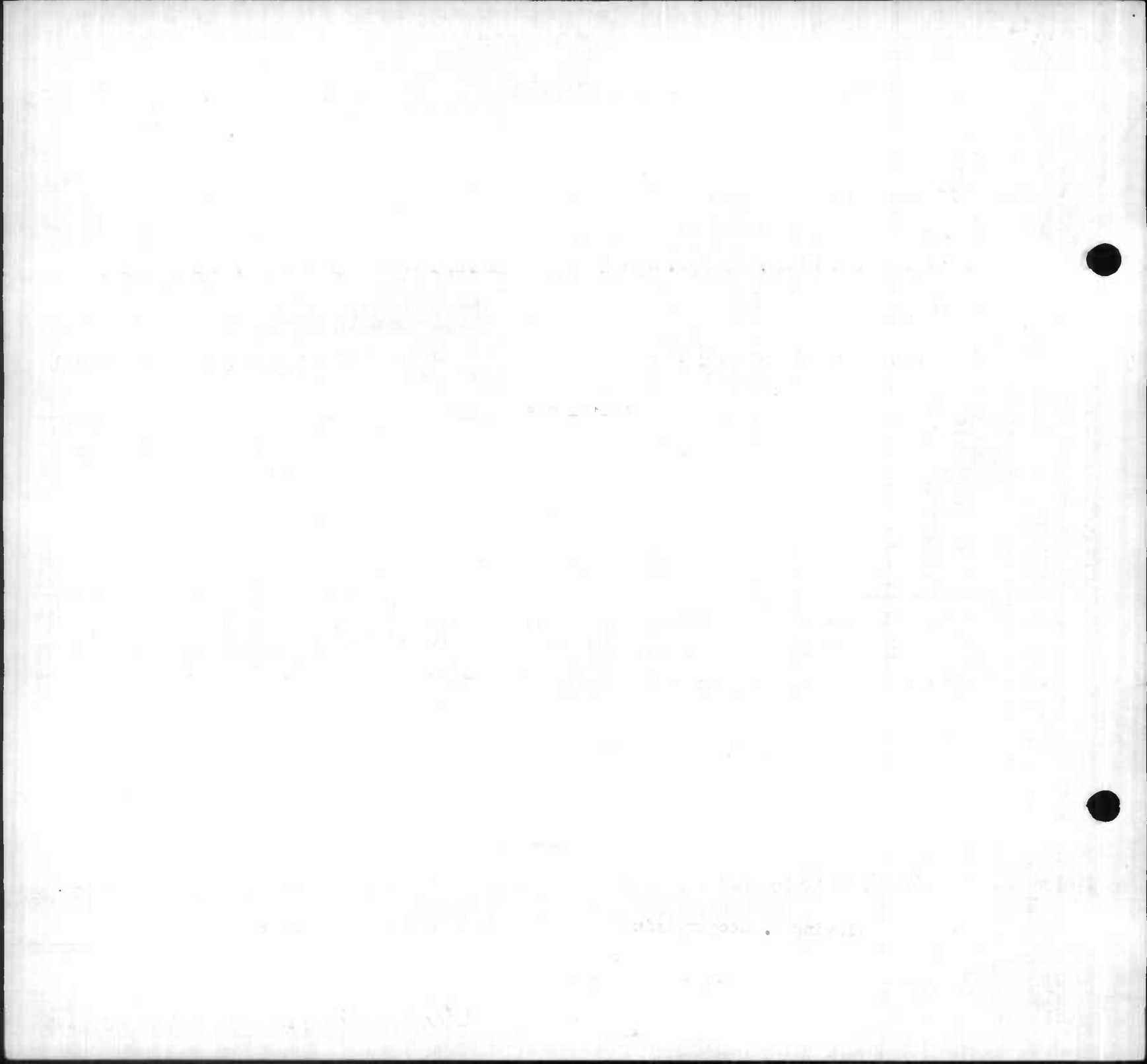
| BIRTH NO. 65 1416 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1416 | | | |
|--|-------------------------|--|---|--|---|--|------------------------------|---|---------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) WEIL MAGDALENA | | | | 2. DATE AND HOUR OF DEATH FEB 4, 1965 | | | | 7:15A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28, MARYLAND D. STREET ADDRESS (If rural, give location) 4703 WILKENS AVE. | | | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4-22-87 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME AUGUST DOERR | | | | 14. MOTHER'S MAIDEN NAME MINNIE NEVER MYER | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 213 48 8127 | | 17. INFORMANT ST AGNES HOSPITAL CATON & WILKENS | | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction | | | | CAUSE OF DEATH fracture dislocation of right elbow | | | | INTERVAL BETWEEN ONSET AND DEATH 35 hours | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fracture - dislocation Rt. Elbow | | | | MEDICAL EXAMINER RELEASED TO DR. RAMNATH | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 21A. DATE OF OPERATION D | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? 4703 Wilkens Ave | | (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.) 2 2 65-12/30 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell from toilet | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB 2 19 65 to FEB 4 19 65 , that (I) (we) last saw the deceased alive on FEB 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE R. Ramnath | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 214165 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. R. RAMNATH | | | | 23D. ADDRESS ST AGNES HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-6-65 | | 24C. NAME of CEMETERY or CREMATORY Western Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave-21229 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

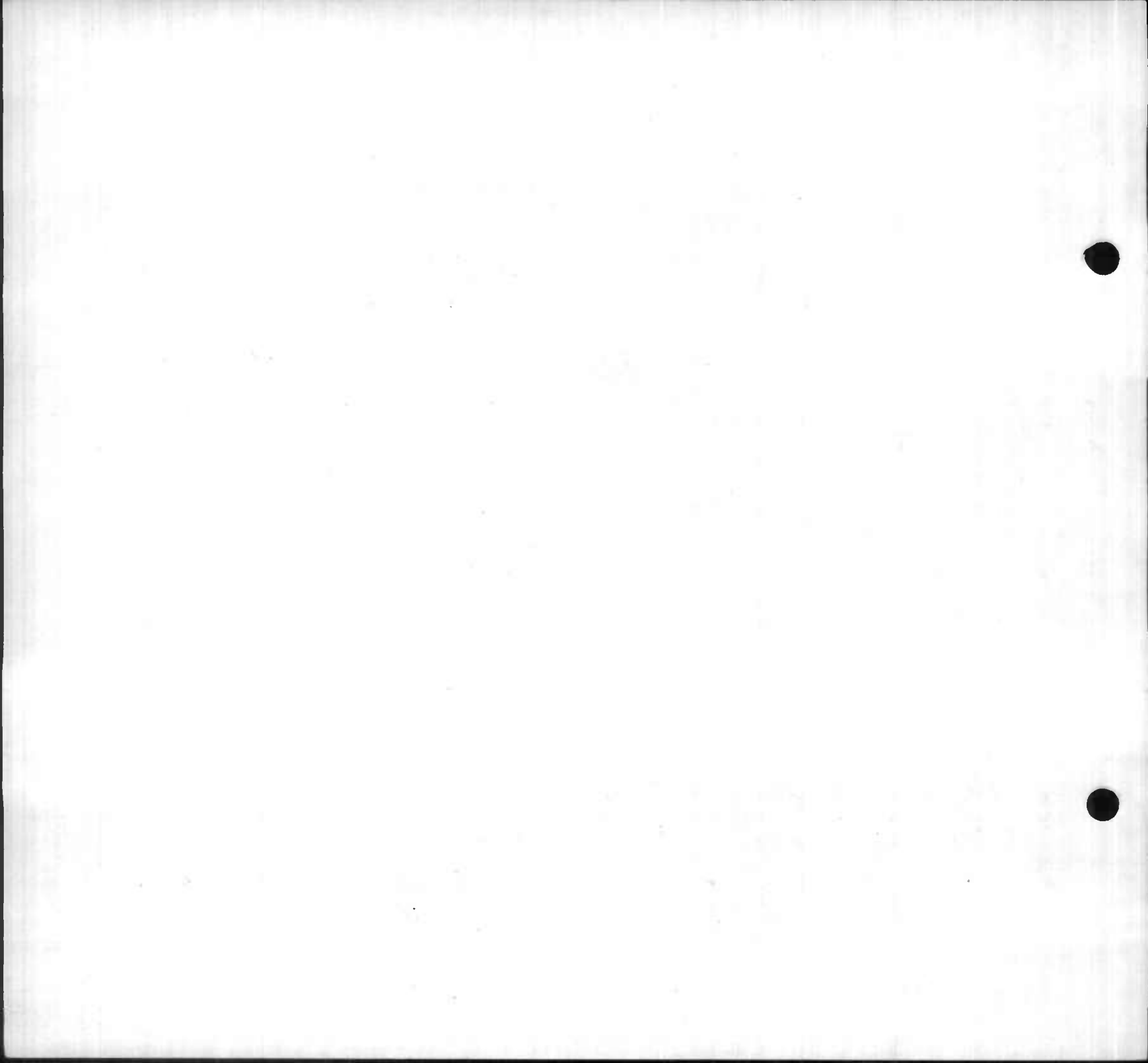
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|--|--------------|--|----------------------------------|---|---|
| BIRTH NO. 65 1417 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1417 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARGARET KOLIOPOULOS | | 2. DATE AND HOUR OF DEATH FEB 2, 1965 9:10 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY WASHINGTON | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) HAGERSTOWN 71-23 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL | | D. STREET ADDRESS (If rural, give location) 25 LAUREL ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH JUNE 3, 1890 | 9. AGE (In years last birthday) 74 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) HAGERSTOWN MD. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME CHARLES B. BOYLE | | 14. MOTHER'S MAIDEN NAME SMITH (MARY JOSEPHINE SMITH) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217-10-2705 | 17. INFORMANT ADDRESS CHART. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.0 + 260 X CONGESTIVE HEART FAILURE | | CAUSE OF DEATH (A) DUE TO CONGESTIVE HEART FAILURE | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS | | (B) DUE TO ARTERIOSCLEROTIC HEART DISEASE | | | |
| (C) DUE TO | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (it) (this hospital) attended the deceased from JAN. 19, 1965 to FEB. 2, 1965, that (it) (we) last saw the deceased alive on FEB. 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Irving L. Cooperstein | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED FEB. 2, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein | | 23D. ADDRESS M.D. MONTEBELLO STATE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE FEB 6 1965 | | 24C. NAME OF CEMETERY or CREMATORY ROSE HILL CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR HAGERSTOWN MARYLAND | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

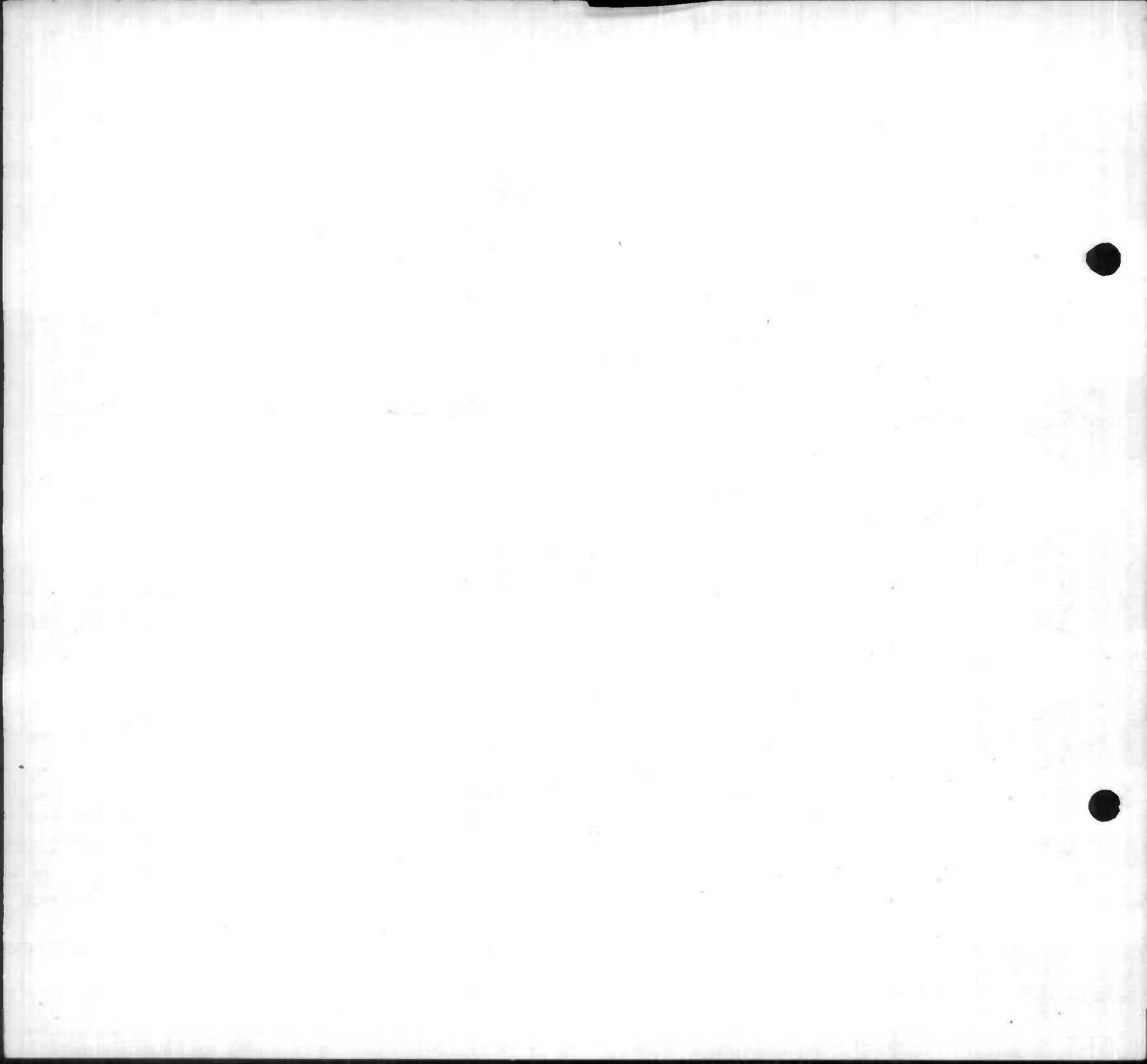
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|--|---------------|--|--|--|--|
| BIRTH NO. 65 1418 | | CITY OF BALTIMORE HEALTH DEPARTMENT | | REGISTERED NO. 65 1418 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN M. BETLEJEWSKI (BAILEY) | | | |
| 2. DATE AND HOUR OF DEATH | | FEBRUARY 2 1965 6 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND B. COUNTY 1-13 | | | |
| 602 SOUTH ROSE ST. BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 602 SOUTH ROSE ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH MARCH 3 1907 | 9. AGE (In years last birthday) 57 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY NATIONAL CAN CO. | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME MARTIN BETLEJEWSKI | | 14. MOTHER'S MAIDEN NAME CATHERINE SMIGLEWSKI | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-10-2016 | 17. INFORMANT ADDRESS MRS. CATHERINE BETLEJEWSKI 602 S. ROSE ST. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | (A) DUE TO Coronary Occlusion | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Arteriosclerosis Generalized | | | |
| | | (C) Hypertension C.V.D. Central Vascular Accident | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 1965 to Feb 2 1965 and that (I) (we) last saw the deceased alive on Feb 1 1965 and that (my) (our) apianian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) M. F. JAWORSKI | | 23D. ADDRESS 2911 Eastern Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-6-65 | | 24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM. | |
| 24D. LOCATION BALTIMORE | | 24E. LOCATION (City, town, or county) MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 8 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS RAYMOND L. KACZOROWSKI 3525 FLEET ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

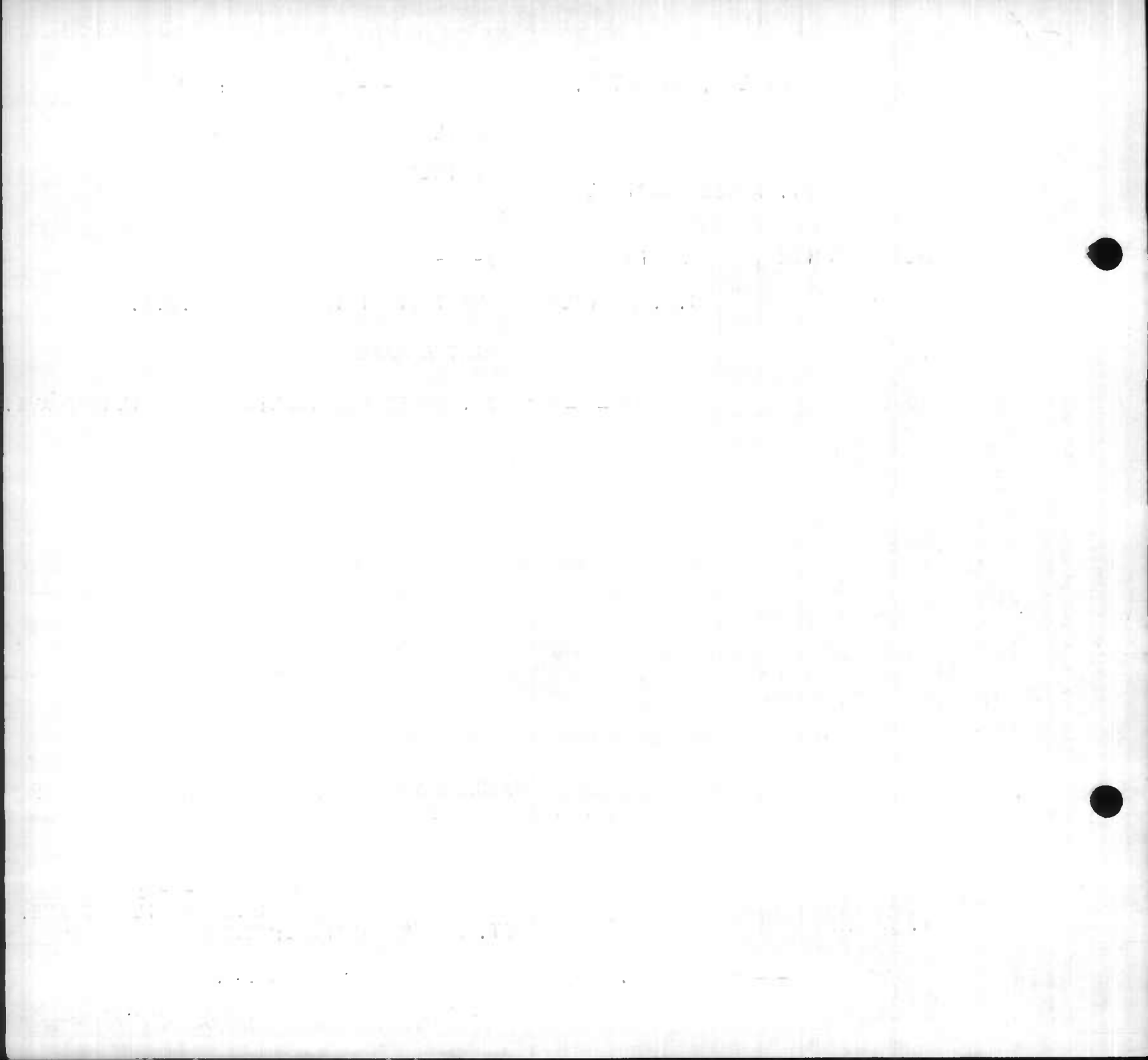
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|--|---|---|---|--|
| 65 1419 | | | | | 65 1419 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>GUYION D. Lupton</u> | | | | | 2. DATE AND HOUR OF DEATH <u>2-3-65</u> <u>2:15</u> P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Baltimore</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS Hospital</u> <u>Baltimore Md.</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>6914 Ridgeway Rd.</u> <u>22</u> | | | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>2/14/09</u> | 9. AGE (in years last birthday) <u>55</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co</u> | | | 11. BIRTHPLACE (State or foreign country) <u>N. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Jack Lupton</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>SALLY DAVIS</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>213-07-3898</u> | | 17. INFORMANT <u>MRS. ANNA LUPTON</u> | | | ADDRESS <u>6914 RIDGEWAY</u> | |
| 18. <u>157X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Intestatic adenoma of Pancreas</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (A) DUE TO <u>Intestatic adenoma of Pancreas</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from <u>1-15</u> 19 <u>65</u> to <u>2-3</u> 19 <u>65</u> , that (1) <u>we</u> last saw the deceased alive on <u>2-2</u> 19 <u>65</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>Two</u> (did) <u>did not</u> view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>C. C. Linantud, Jr.</u> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>2-3-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>C. C. LINANTUD, JR.</u> M.D. | | | | | 23D. ADDRESS <u>BON SECOURS HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-6-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART OF JESUS</u> | | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Co. MD.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 8 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u> | | | ADDRESS <u>2525 FLEET ST.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

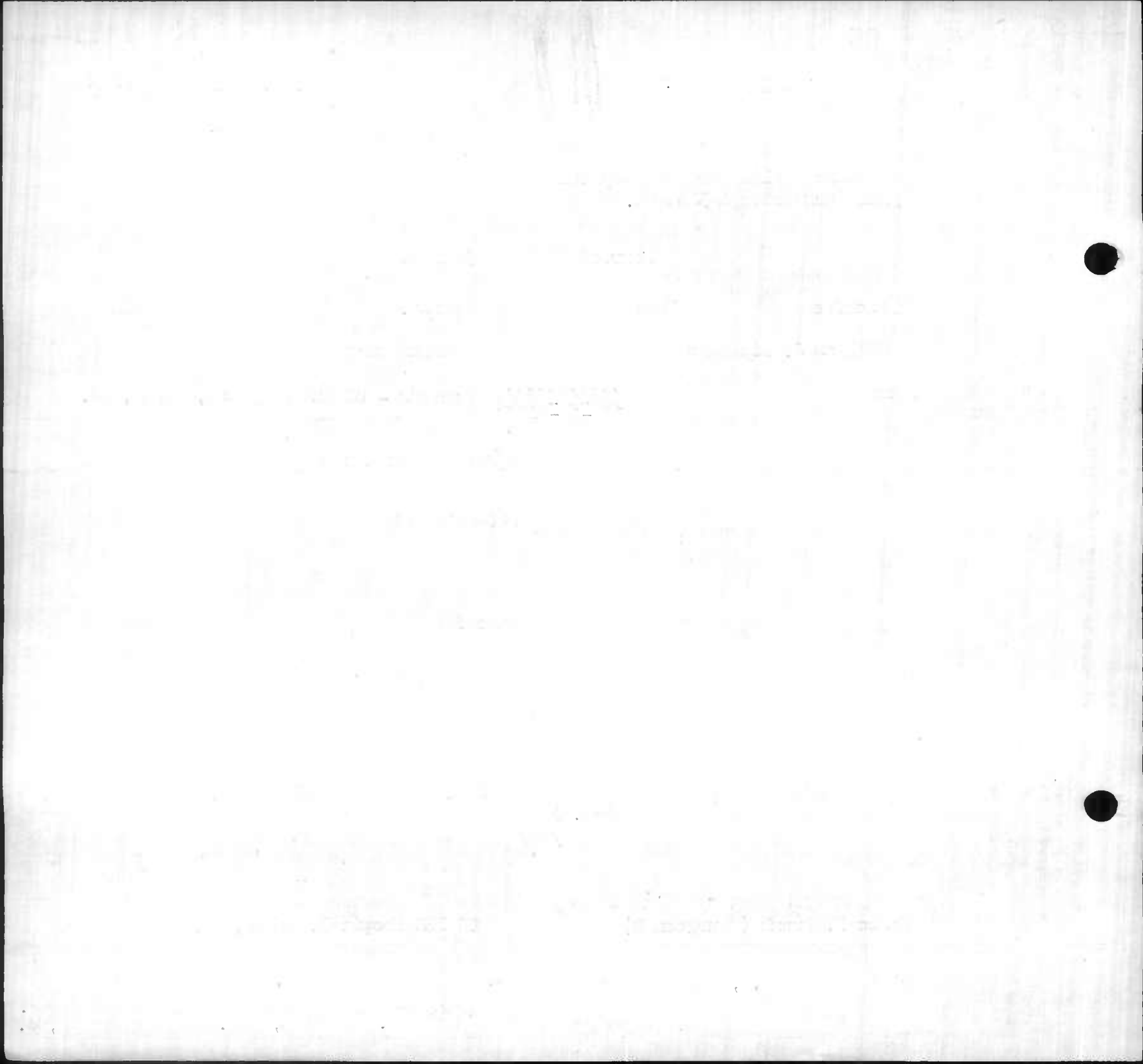
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---|--|---|---|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1420 | | | | |
| BIRTH NO. 65 1420 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) HUTSLER, ROBERT M. | | | | | 2. DATE AND HOUR OF DEATH 2-4-65 8:30P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | | MARYLAND | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) DANIELS | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-27-96 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR | | | 10B. KIND OF BUSINESS OR INDUSTRY C.R. DANIELS | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME STEVE | | | | | 14. MOTHER'S MAIDEN NAME MARTHA MASON | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | | 16. SOCIAL SECURITY NO. 232-26-5373 | | 17. INFORMANT ST. AGNES HOSPITAL; CATON & WILKENS AVE. | | | | |
| 18. 153.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Cancer Cecum is generalized metastasis (B) DUE TO (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 24 19 65 to FEBRUARY 4 19 65 , that (I) (we) lost saw the deceased alive on FEBRUARY 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE V. Rubin M.D. | | | | | 23B. DATE SIGNED 2-4-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) V. RUBIN | | | | | 23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE. #29 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-8-1965 | | 24C. NAME of CEMETERY or CREMATORY Mt. Carmel | | 24D. LOCATION (City, town, or county) (State) Glengary, W. Va. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR F.C. Higginbotham | | ADDRESS Ellicott City, Md | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

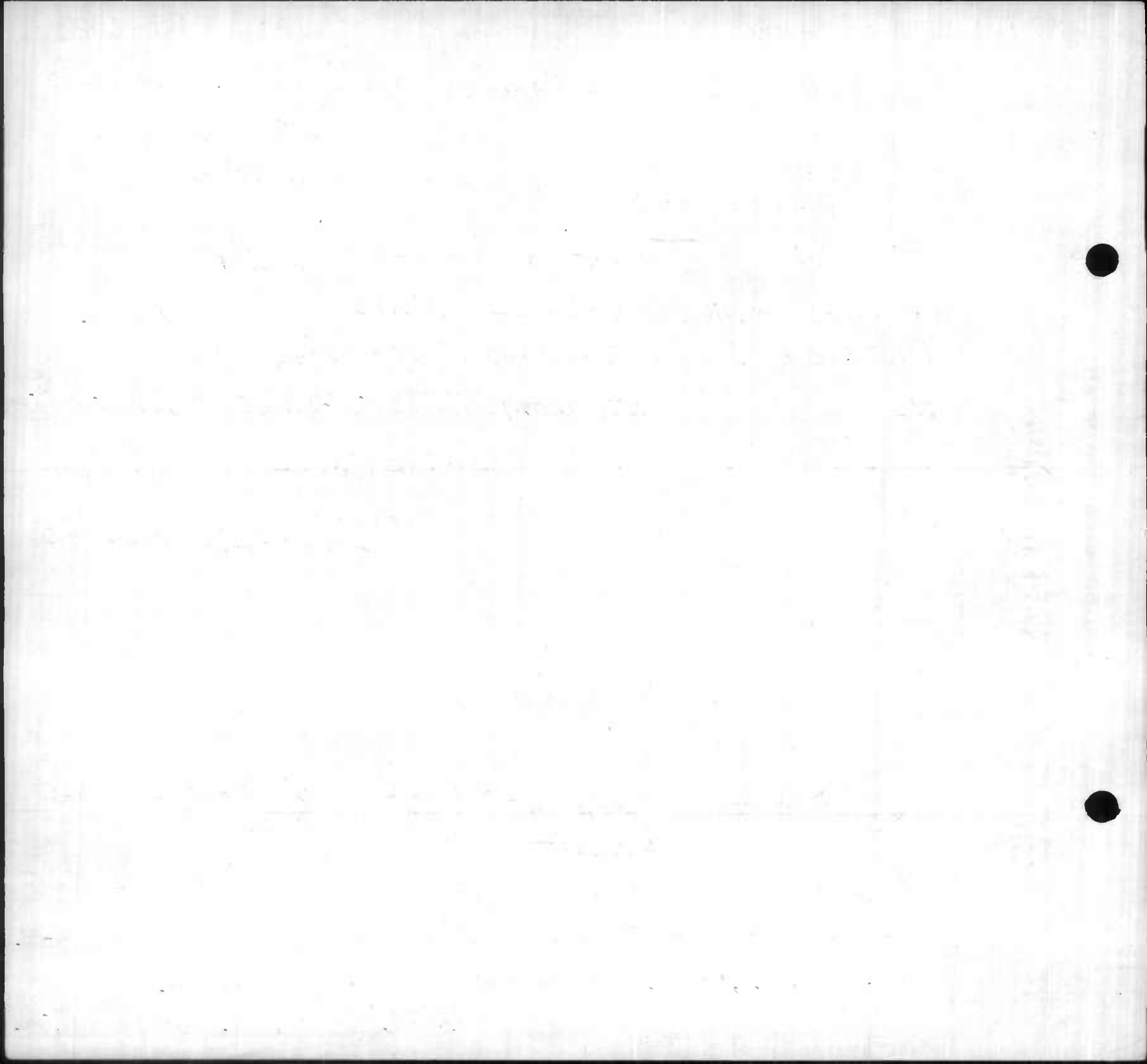
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|---|--|--------------|--|---|---|-----------------------------|--|---------------------------------------|--|--|--|-----------------------|--|--|--|--|
| BIRTH NO. 65 1421 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1421 | | | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | M. | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MIRIAM SHEWAN | | | | | Feb. 3, 1965 | | | | | 11 AM | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Park Drive & 31st St. | | | | | A. STATE B. COUNTY Maryland Montgomery | | | | | | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Silver Springs 65-00 | | | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 8385 16th Street | | | | | | | | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3/25/95 | | 9. AGE (In years last birthday) 69 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | | | | 11. BIRTHPLACE (State or foreign country) Penna. | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William J. Nicholas | | | | | 14. MOTHER'S MAIDEN NAME Miriam Barry | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) None | | | | | 16. SOCIAL SECURITY NO. 165-20-8599 | | | | | 17. INFORMANT Records - US PHS Hospital, Balto, Md. | | | | | ADDRESS | |
| 18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Aspiration pneumonia (A) DUE TO Terminal | | | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Lymphosarcoma (B) DUE TO 1 month | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Leukemia | | | | | | | | | | | | | | | Terminal | |
| 19A. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Jan. 26 19 65 to Feb. 3 19 65, that (1) (we) last saw the deceased alive on Feb. 3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE James H. Frank, M.D. | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 2/3/65 | |
| 23C. PHYSICIAN'S NAME (Type) James H. Frank (Surgeon R) | | | | | | | | | | M.D. 23D. ADDRESS US PHS Hospital, Balto, Md. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE Feb. 6, 1965 | | | | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park | | | | | 24D. LOCATION (City, town, or county) (State) Elkridge, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | | | | 25C. FUNERAL DIRECTOR Raymond A. Ziska Warner E. Pumphrey, Inc. | | | | | ADDRESS 8434 Georgia Ave. Silver Spring, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

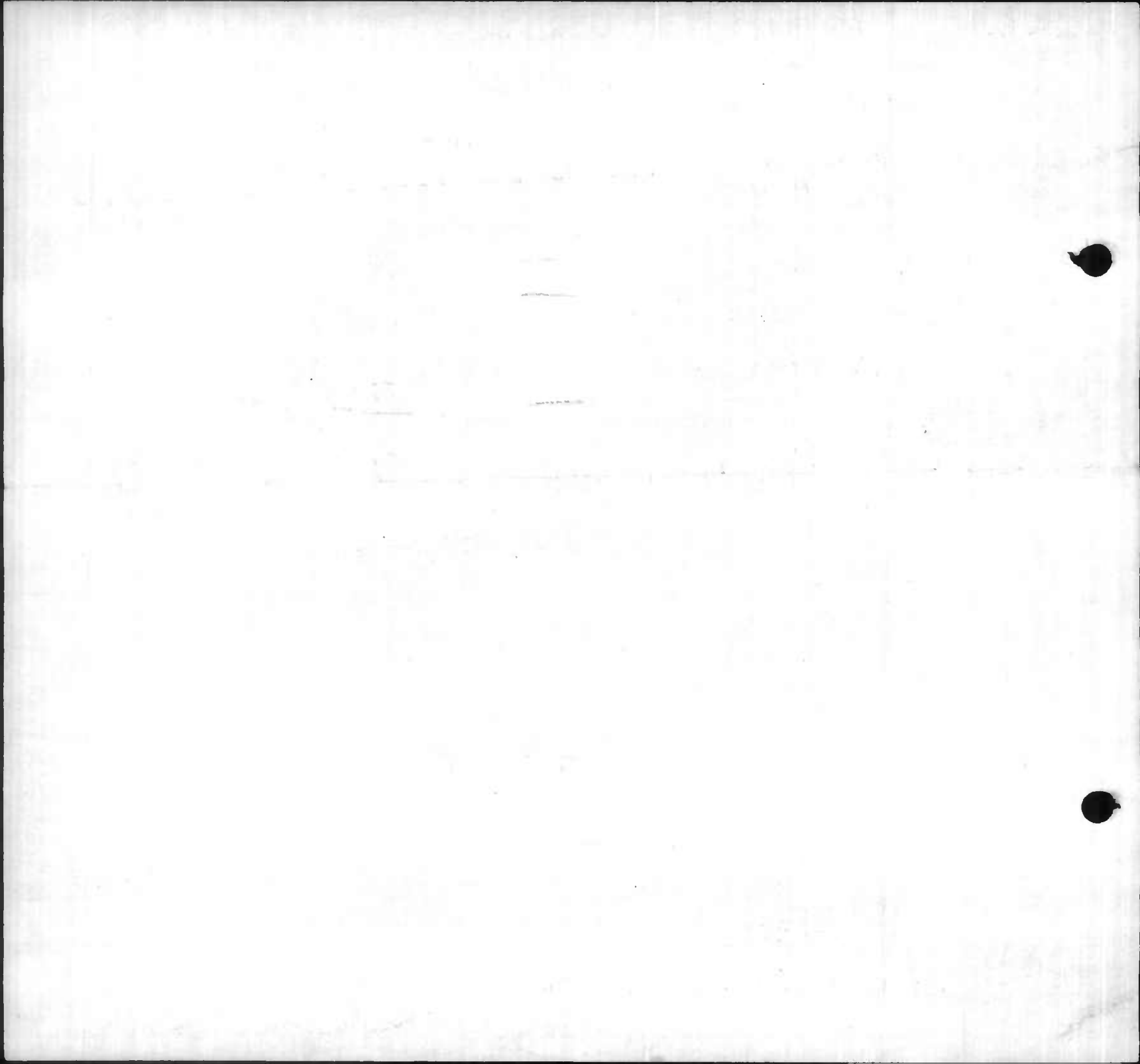
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1422</u> | | | | |
| BIRTH NO. <u>65 1422</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>KING, CECELIA FRANCES</u> | | | | | 2. DATE AND HOUR OF DEATH <u>FEB. 2, 1965</u> <u>4 50 P</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>U.S.P.H.S. HOSP. BALTO, MD.</u> | | | | | A. STATE <u>MD.</u> B. COUNTY <u>Montgomery</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>SILVER SPRING 65-00</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>9209 Worth Avenue</u> | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SEPARATED</u> | | | 8. DATE OF BIRTH <u>8-1-03</u> | 9. AGE (In years last birthday) <u>61</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE-TEACHER (HOME + SCHOOL)</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>MASS</u> | | 11. BIRTHPLACE (State or foreign country) <u>MASS</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 13. FATHER'S NAME <u>PATRICK J. FITZGERALD</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>CATHERINE O'Connor</u> | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>578-46-419</u> | | | | | 17. INFORMANT <u>Miss Mary E. Fitzgerald</u> | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTICEMIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ACUTE MYELOCYTIC LEUKEMIA</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Terminated</u> <u>SEVERAL MONTHS</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>JAN 22</u> 19 <u>65</u> to <u>FEB 2</u> 19 <u>65</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>FEB 2</u> 19 <u>65</u> and that in <u>(our)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Frank A. Bartkus</u> M.D. | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>FEB. 2, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FRANK A. BARTKUS</u> M.D. | | | | | | 23D. ADDRESS <u>U.S.P.H.S. HOSP. BALTO, MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Feb. 8, 1965</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Patrick's Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Chicopee Falls, Mass.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.A.</u> | | | 25C. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> | | ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 1423 | |
|--|------------------|---|---|---|---|
| BIRTH NO. 65 1423 | | | | | |
| M.E. CASE NO. 7888 | | | | | |
| 1. NAME OF DECEASED (Type or Print) SISTERE KIGIA (TYSZKIEWICZ) | | 2. DATE AND HOUR OF DEATH 3/7/65 | | 3:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Batto. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION P.O.A. Church HOME. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. MD. | | | |
| | | D. STREET ADDRESS (If rural, give location) 2712 O'Donnell St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH Dec. 6, 1893 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Poland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John | | 14. MOTHER'S MAIDEN NAME Anna Humel | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sister M. Anisetta, F.I.L.D. | |
| 18. 443X1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Arteriosclerotic cardiovascular heart disease with hypertension | | 6 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) and encephalopathy | | 7-8 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 18 Jan 65 19 to 25 Jan 65 19 that (I) (we) lost saw the deceased alive on 25 Jan 65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph B. Bronush | | | | 23B. DATE SIGNED 4/7/65 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH B. BRONUSH | | 23D. ADDRESS JOSEPH B. BRONUSH, M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-6-1965 | | 24C. LOCATION (City, town, or county) (State) BALTIMORE 24, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Marie Hallows | |
| | | | | ADDRESS 1000 S. KENNEDY AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------|--|--|--|--|--|------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1424 | | | | |
| BIRTH NO. 65 1424 | | | | | WRIGHT | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) James Wright | | | | | Feb. 8, 1965 4:50 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General | | | | | A. STATE Maryland | | | | |
| | | | | | B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cherry Hill | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3020 Ascension St. | | | | |
| 5. SEX M. | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct. 8, 1910 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY Mill work | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George A. Wright | | | | | 14. MOTHER'S MAIDEN NAME Della Waters | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 214 10 6051 | | 17. INFORMANT Mrs. E. Wright, 3020 Ascension Ave. | | | | ADDRESS |
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | (A) DUE TO Hypertensive C.R.D. | | | 1960 | |
| | | | | | (B) DUE TO Bronchial Asthma | | | 1956 | |
| | | | (C) DUE TO Cardiac decompensation | | | 2-2-65 | | | |
| 19A. DATE OF OPERATION 0 none | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-24-1964 to 2-2-1965, that (I) (we) last saw the deceased alive on 2-2-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE T.D. Trifer | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-8-65 | | |
| 23C. PHYSICIAN'S NAME (Type) T.D. Trifer | | | | | 23D. ADDRESS 1228 N. Caroline St | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/13/65 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Wesley Cem. | | 24D. LOCATION (City, town, or county) (State) Snow Hill, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS New Church, Va. | | | |

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65 1425

BALTIMORE CITY HEALTH DEPARTMENT

65 1425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GORDON LEE THORNTON

2. DATE AND HOUR PRONOUNCED DEAD

February 3, 1965 1:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4708 Williston Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-10-04

9. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Reproduction

10B. KIND OF BUSINESS OR INDUSTRY

Engineering Corp.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Clarence Thornton

14. MOTHER'S MAIDEN NAME

Hattie Landon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Irene E. Thornton-4708 Williston St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
2/4/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

2-6-65

23C. NAME OF CEMETERY or CREMATORY

Lakeview Cemetery

23D. LOCATION

(City, town, or county) (State)
Carroll County, Md.
Liberty Rd. & Oakland Mill Rd.

24A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

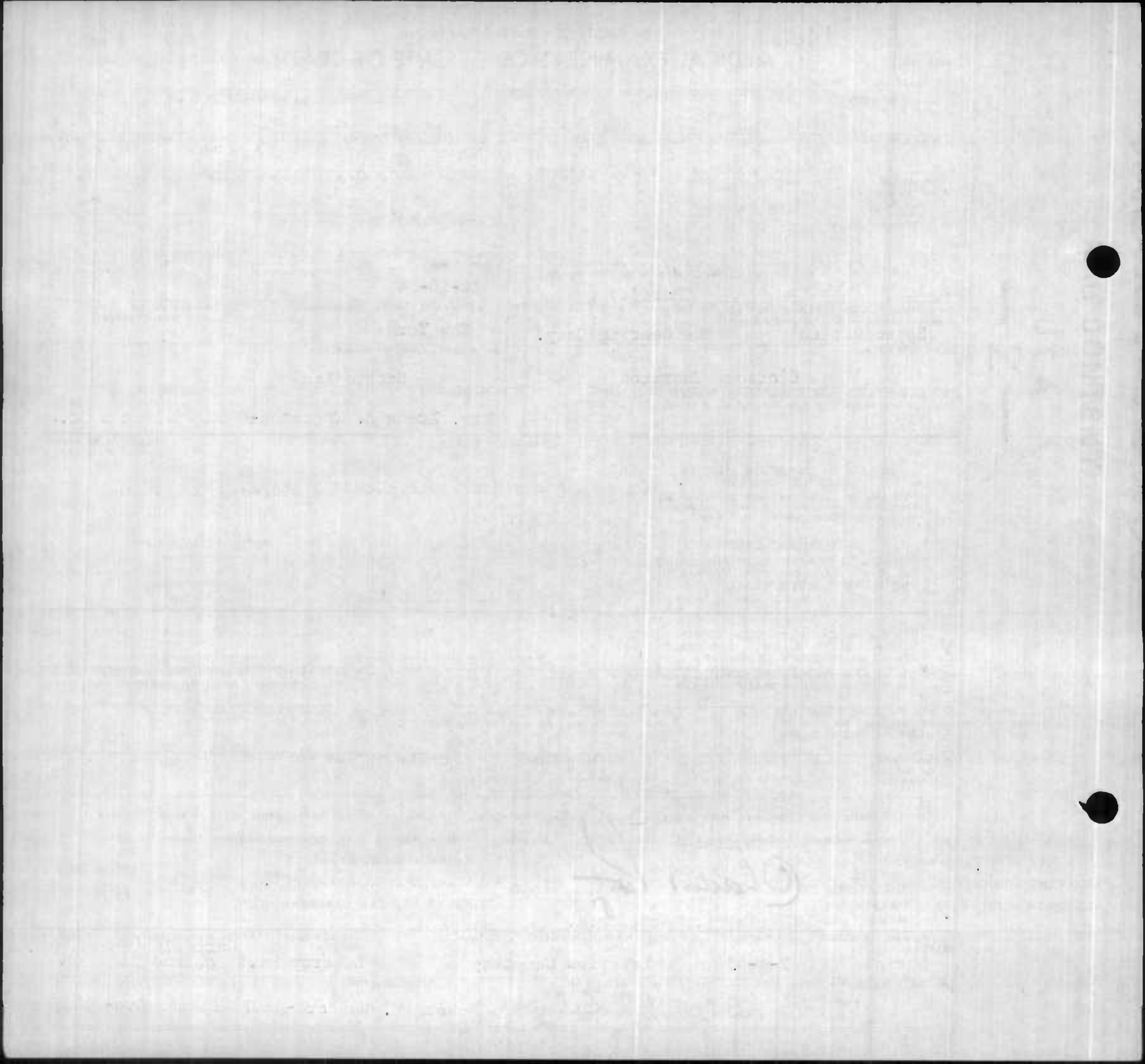
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Howard H. Hubbard-4107 Wilkens Ave-21229

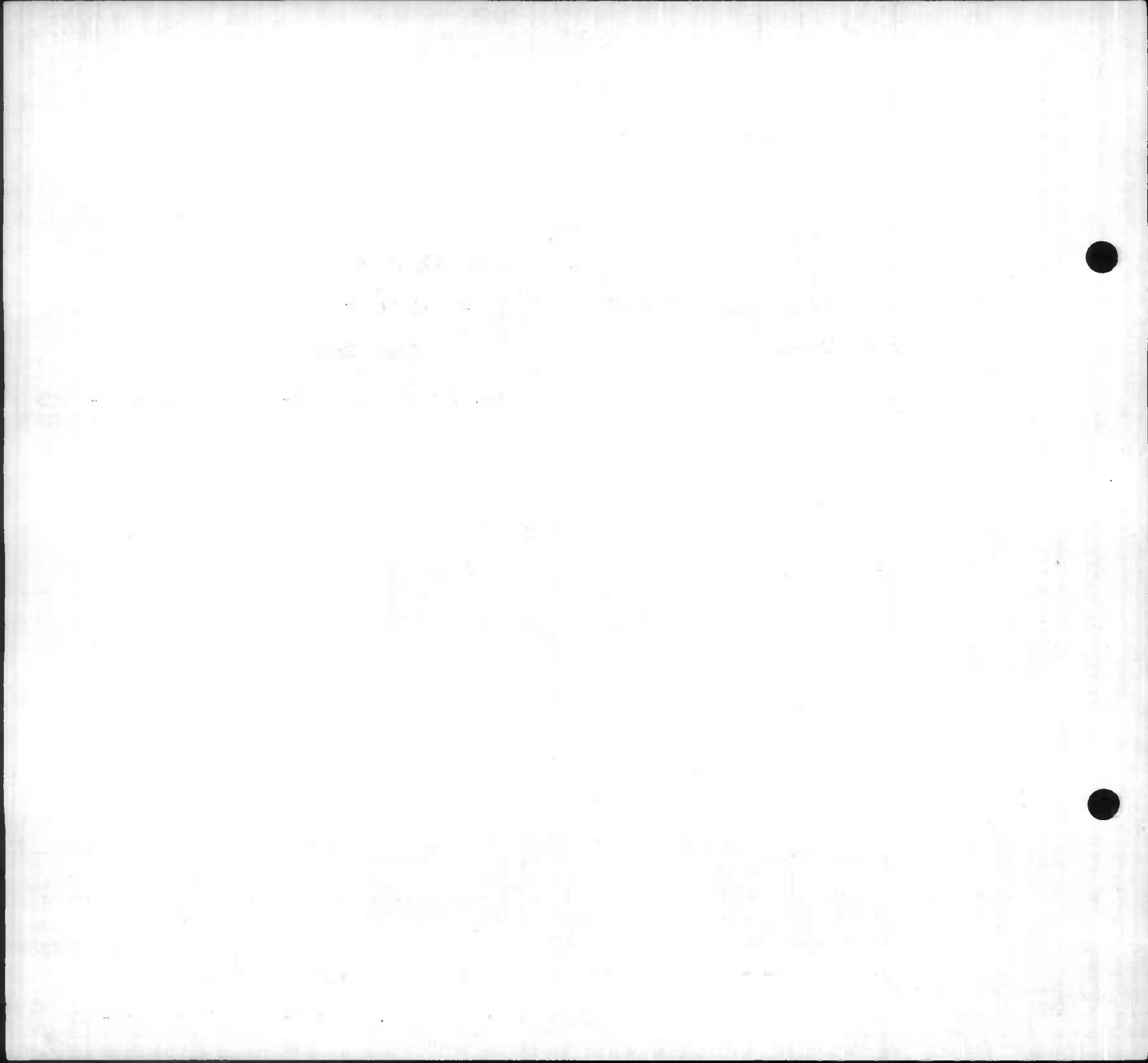
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|---|--|---|
| 65 1426 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1426 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) CAMPBELL, NORA AGNES | | 2. DATE AND HOUR OF DEATH Feb. 4, 1965 5:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL BALTIMORE 23, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1904 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 23 D. STREET ADDRESS (If rural, give location) 1720 W. LOMBARD ST. # 23 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH Sept 25, 1892 | 9. AGE (In years last birthday) 72 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTH PLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Daniel Fleck | | | 14. MOTHER'S MAIDEN NAME Mildred Farren | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Francis Campbell-2829 Sunset Drive-21223 | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | (A) DUE TO Myocardial Infarction | | |
| | | | (B) DUE TO Acute coronary heart disease | | |
| | | | (C) DUE TO Arteriosclerotic Cardiovascular undetermined disease | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerotic Cardiovascular Disease | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 31 1965 to Feb 4 1965 , that (I) (we) last saw the deceased alive on Feb 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Gertrude C. Palad | | | | 23B. DATE SIGNED Feb 4, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ZENAIDA C. PALAD | | 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-8-65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229 | |



| BALTIMORE CITY HEALTH DEPARTMENT | | 65 1427 | |
|---|-------------------------|---|--------------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____ | | | |
| BIRTH NO. _____ | | M.E. CASE NO. _____ | |
| 1. NAME OF DECEASED (Type or Print) ANNA ORBINO | | 2. DATE AND HOUR PRONOUNCED DEAD February 2, 1965 10:35 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital DOA | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-41 D. STREET ADDRESS (If rural, give location) 1020 Rockhill Avenue | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 7/13/1914 |
| 9. AGE (in years last birthday) 47 50 Yrs | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress, Retired | | 10B. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? _____ | |
| 13. FATHER'S NAME Samuel Finazzo | | 14. MOTHER'S MAIDEN NAME Grace | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. 220-32-2919 | |
| 17. INFORMANT Mr. Salvator Orbino, 1109 Wynbrook Rd. Md. | | ADDRESS GlenBurnie | |
| 18. CAUSE OF DEATH 4221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO _____ (B) DUE TO _____ (C) DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-3-65 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2/6/1965 | |
| 23C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 24C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. #29 | | ADDRESS _____ | |

MILLER POLICE

FOR COMMISSION

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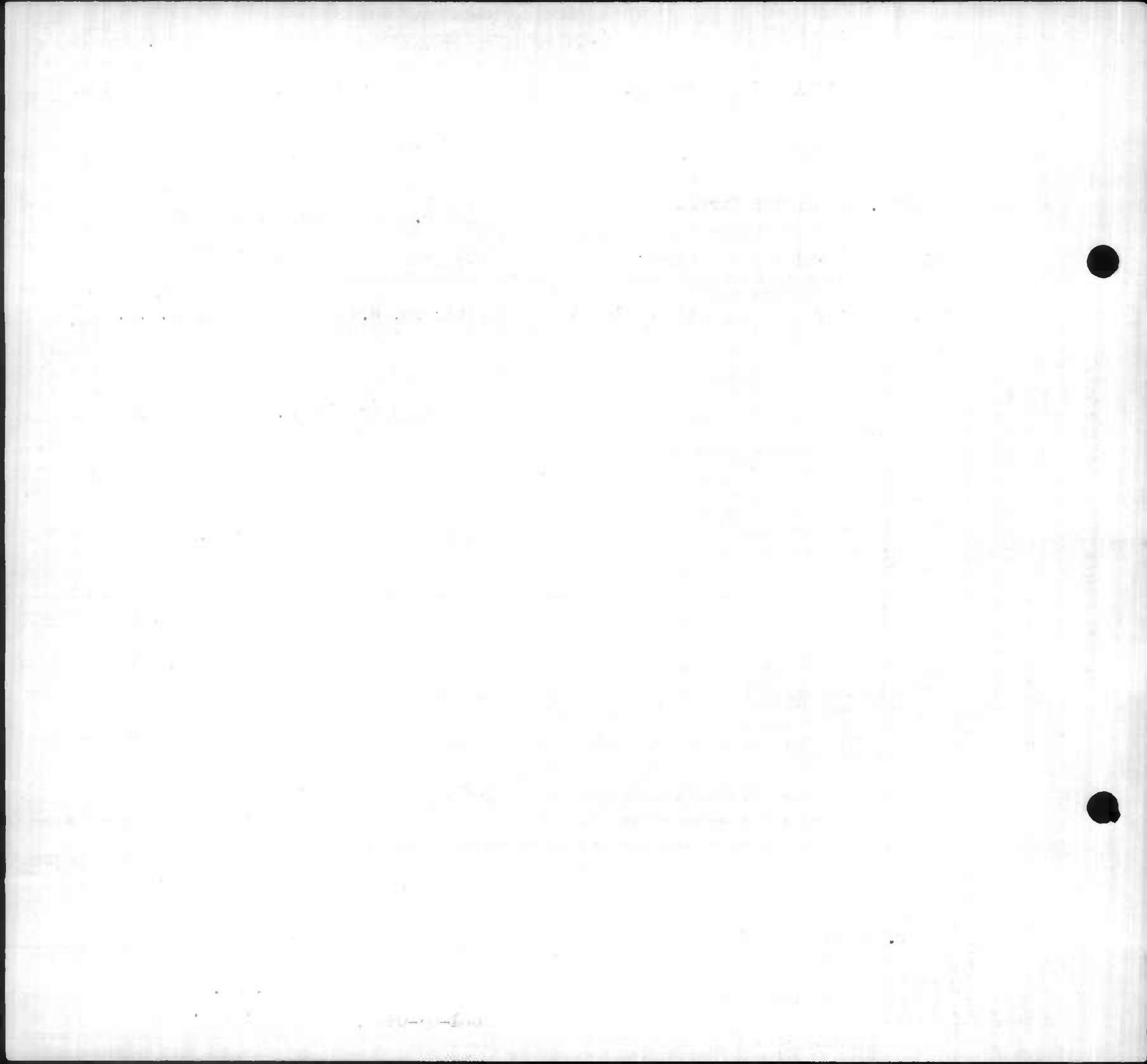
1964

1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

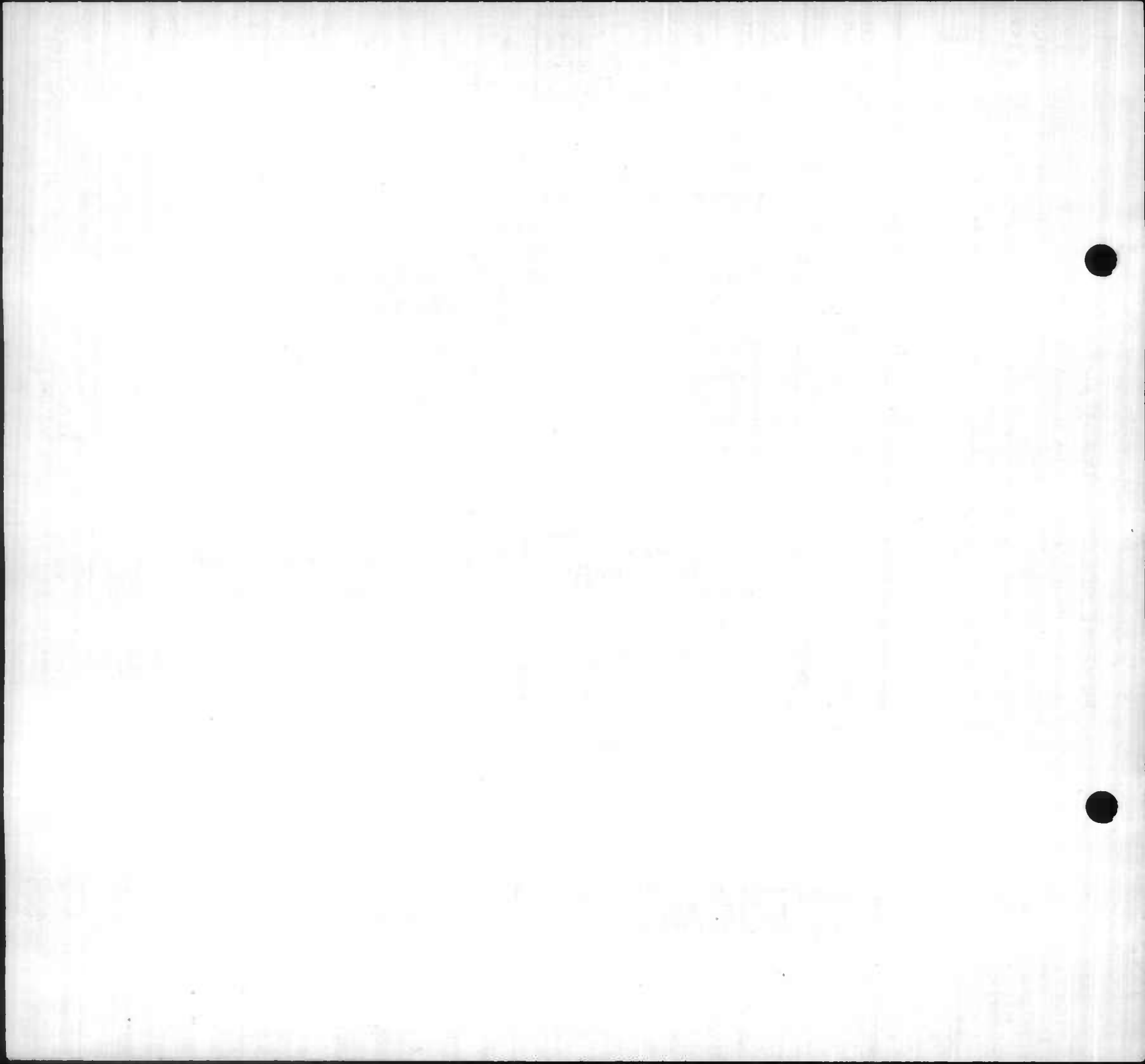
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1428 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 65 1428 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) William Paul Rothaupt | | | 2. DATE AND HOUR OF DEATH February 3, 1965 10 am M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 108 N. Washington Street #31 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 108 N. Washington Street #31 | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 12/5/1892 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter | | 10B. KIND OF BUSINESS OR INDUSTRY Self Employed | 11. BIRTHPLACE (State or foreign country) Baltimore, M.d | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT (dght) Thelma Tabor 702 N. Luzerne Avenue #5 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 491X I Pneumonia (A) DUE TO Chronic Bronchial (B) DUE TO asthma (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH 6 weeks INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 29 19 65 to Dec 29 19 65 and that (I) (we) last saw the deceased alive on Dec 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles MacMinn M.D. | | | | 23B. DATE SIGNED Feb 5, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Charles MacMinn | | | | 23D. ADDRESS 2900 Baltimore Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/6/65 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Schimmeler Funeral Home, Inc. | | | |
| 25D. ADDRESS 2601-03-05 E. Madison Street #5 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

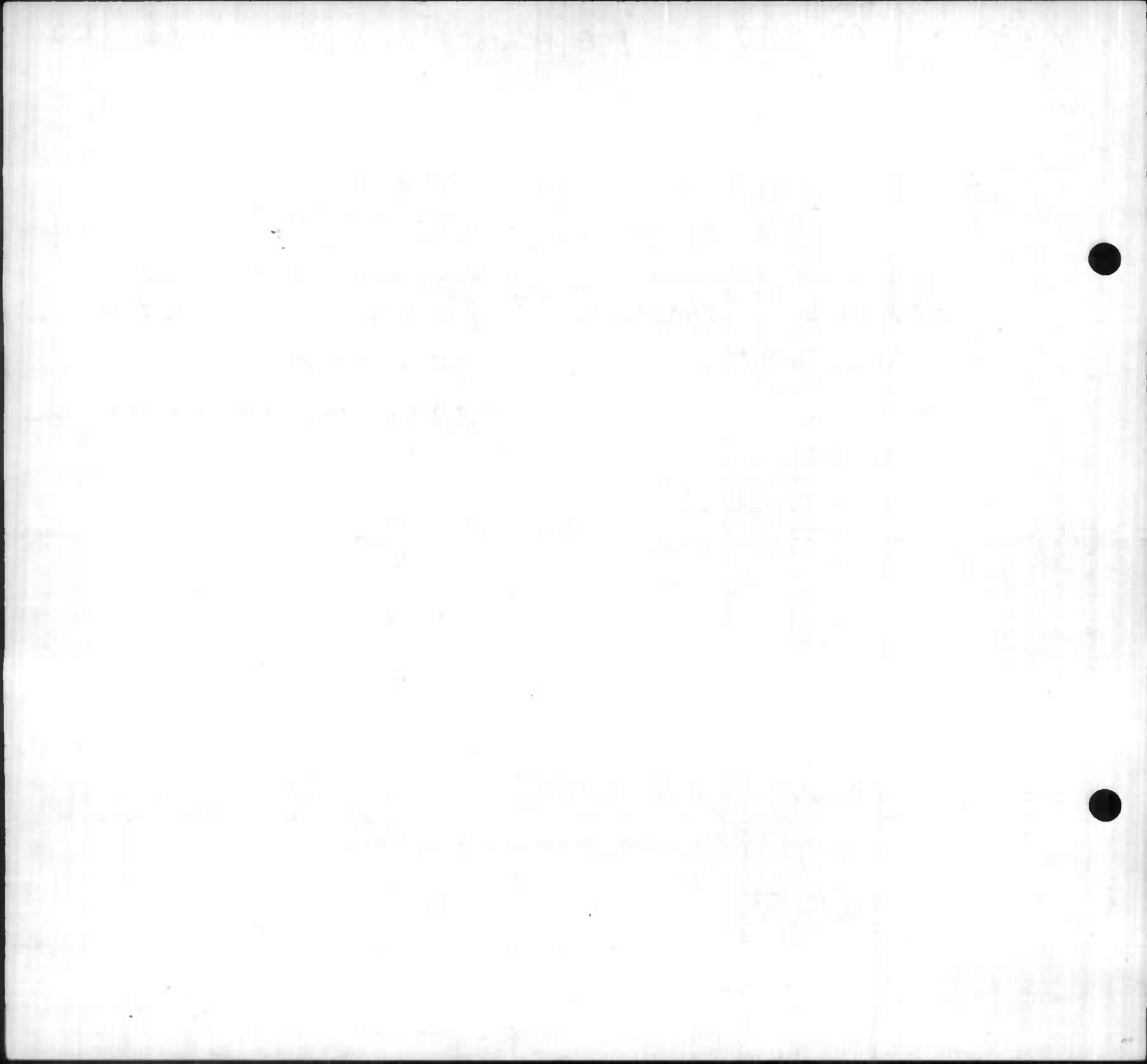
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1429 | |
|--|----------------------|--|----------------------------------|--|--|--|-----------------------|
| BIRTH NO. 65 1429 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MRS BLANCHE E. SMITH | | 2. DATE AND HOUR OF DEATH FEB 4th 1965 7:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL BALTIMORE MD. | | | | A. STATE MD. B. COUNTY BALTIMORE | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6. | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 4431 SHARROCK AVE | | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 11-15-87 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ALFRED JONES | | | | 14. MOTHER'S MAIDEN NAME DORSEY (1ST NAME UNKNOWN) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR GEORGE D SMITH ADDRESS 4431 SHARROCK AVE BALTIMORE 6. | | | |
| 18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocardial heart failure (B) Cirrhosis of liver (C) Brucellosis pneumonia, focal | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN. 31ST 1965 to FEB 4th 1965 , that (we) last saw the deceased alive on FEB. 4th 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Roy S. Patten | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED FEB. 4th 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ROY S. PATTEN | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

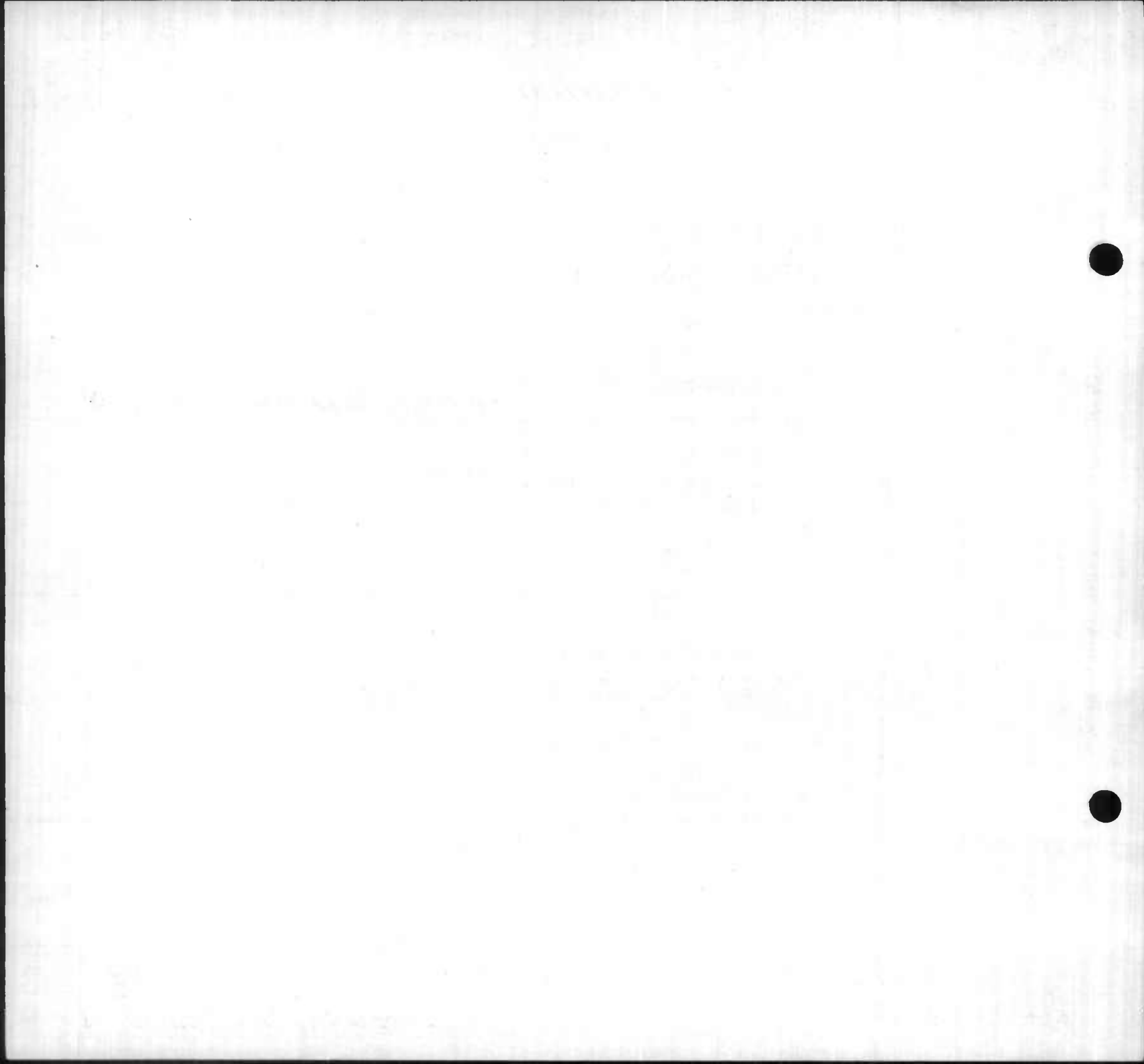
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--------------|---|-----------------------------|---|---|
| BIRTH NO. 65 1430 | | CERTIFICATE OF DEATH | | 65 1430 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Aubrey C. Williams | | 2. DATE AND HOUR OF DEATH 2/5/65 7:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Indiana B. COUNTY V-12 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) New Castle | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) 1132 S. Main St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 1/12/91 | 9. AGE (In years last birthday) 34 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE | | 10B. KIND OF BUSINESS OR INDUSTRY CHRYSLER CORP. | | 11. BIRTHPLACE (State or foreign country) TENN. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Jess Williams | | 14. MOTHER'S MAIDEN NAME Cora Vincent | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT AGNES WILLIAMS - WIFE | |
| 18. 452X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Morgan Syndrome | | CAUSE OF DEATH (A) Hypotension (B) Cerebral Ischemia (C) ? Dissection in Cerebral Artery | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2/2/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypertension / Arteriosclerosis | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 1/22/65 to 2/5/65, that (we) last saw the deceased alive on 2/5/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Azar | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) HORMOZ AZAR | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 2/9/65 | | 24C. NAME OF CEMETERY or CREMATORY Birdstown Cemetery | |
| 24D. LOCATION (City, town, or county) Birdstown, Tenn. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

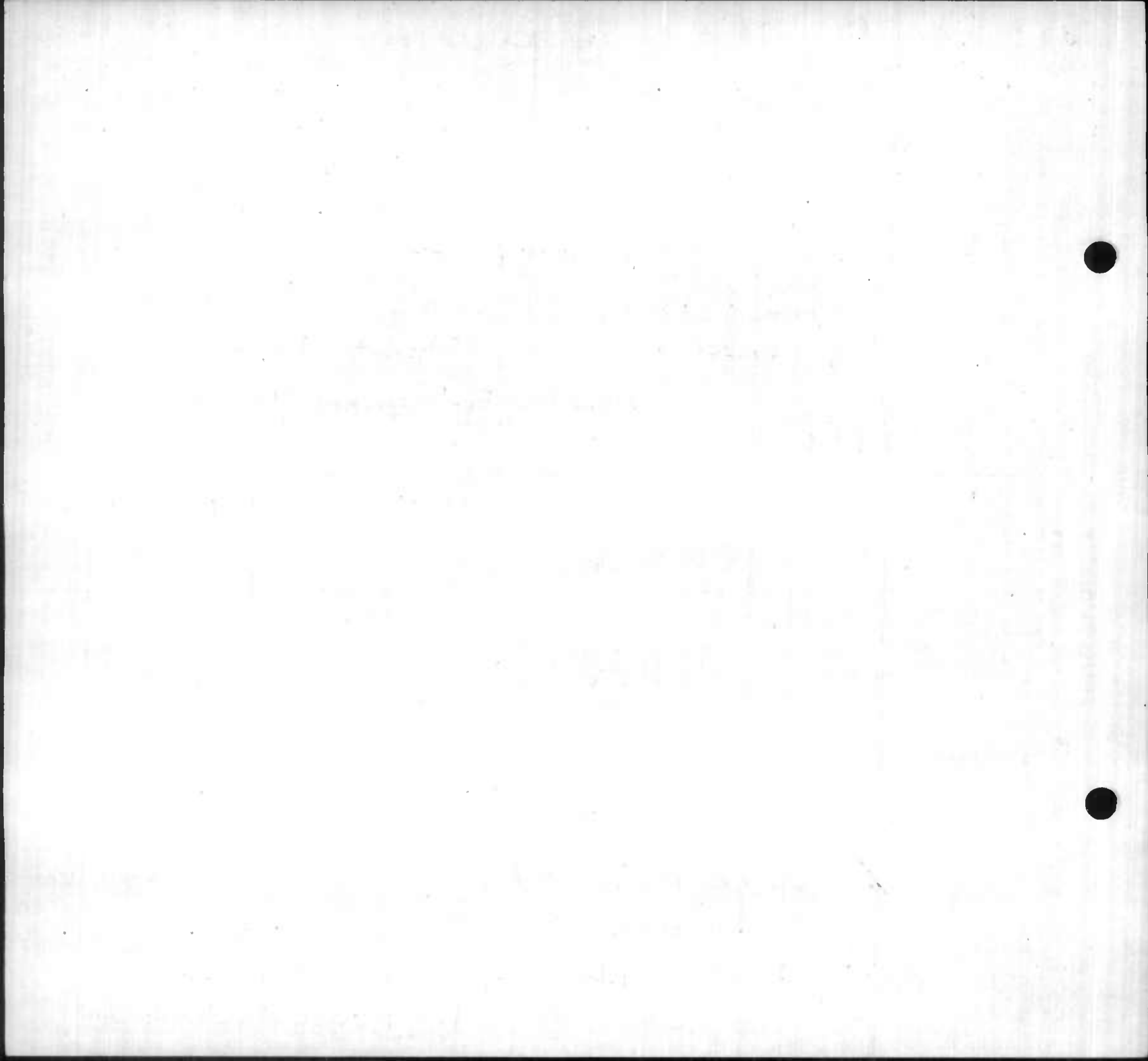
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|--|--|---|---|--|-----------------------------|---|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1431</u> | | | | |
| BIRTH NO. <u>65 1431</u> | | | | | 2. DATE AND HOUR OF DEATH <u>2/1/65 3:30 AM</u> | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ANNA JASKOLSKI JASKOLSKI</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>603</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>2242 EAST FAIRMOUNT AVE.</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u> | | 8. DATE OF BIRTH <u>6-17-98</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <u>ADOLPH MARTINI</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>JULIE SCHISSLER</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>MRS. T. McCulloch 122 N. Cukley St.</u> | | | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO <u>ASCVD</u> (B) _____ DUE TO _____ (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1/31</u> 19 <u>65</u> to <u>2/1</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Jacques R. Caldwell</u> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2/1/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jacques R. Caldwell</u> | | | | | 23D. ADDRESS <u>Johns Hopkins Hospital.</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-5-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MOUNT CARMEL CEM.</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Jaskowski</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>B. DABROWSKI 2814 E. Balto. St.</u> | | | | |



FUNERAL DIRECTOR: IMPORTANT!


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

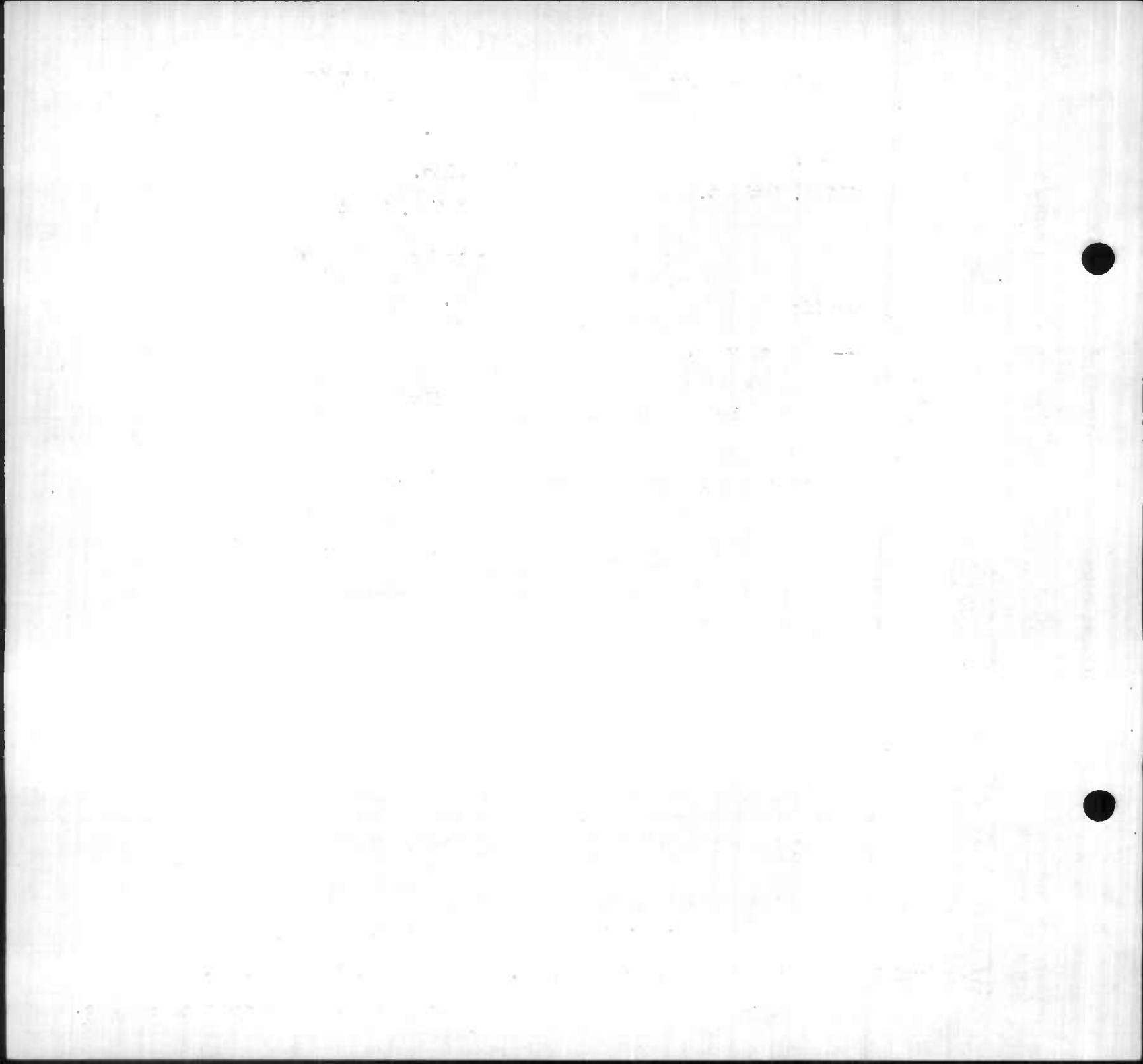
| BIRTH NO. 65 1432 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1432 | |
|---|-------------------------|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Burgan, Marie J. | | | 2. DATE AND HOUR OF DEATH February 5 1965 7.50P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltr C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6 53-00 D. STREET ADDRESS (If rural, give location) 1235 64th St. | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED, NEVER MARRIED single, never married | 8. DATE OF BIRTH 12-2-09 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman | | 10B. KIND OF BUSINESS OR INDUSTRY Bakery | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Joseph BURGAN | | | 14. MOTHER'S MAIDEN NAME Elizabeth DEPPART | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-20-7592 | | 17. INFORMANT ADDRESS Eva BIGGERMAN 7912 32nd St | |
| 18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Diabetes mellitus; arteriosclerosis of coronary arteries; spotty fresh infarcts of myocardium. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION February 3, 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene and occl disease | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 26 19 64 to Feb. 5 19 65 , that (I) (we) last saw the deceased alive on Feb. 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm B. VandeGrift M.D. | | | | 23B. DATE SIGNED February 6, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) William B. VandeGrift, | | | 23D. ADDRESS 1400 N. Caroline St. Balto. 21213 Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-9-65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemers Cemetery Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Philip F. Crach 1211 Chesaco Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

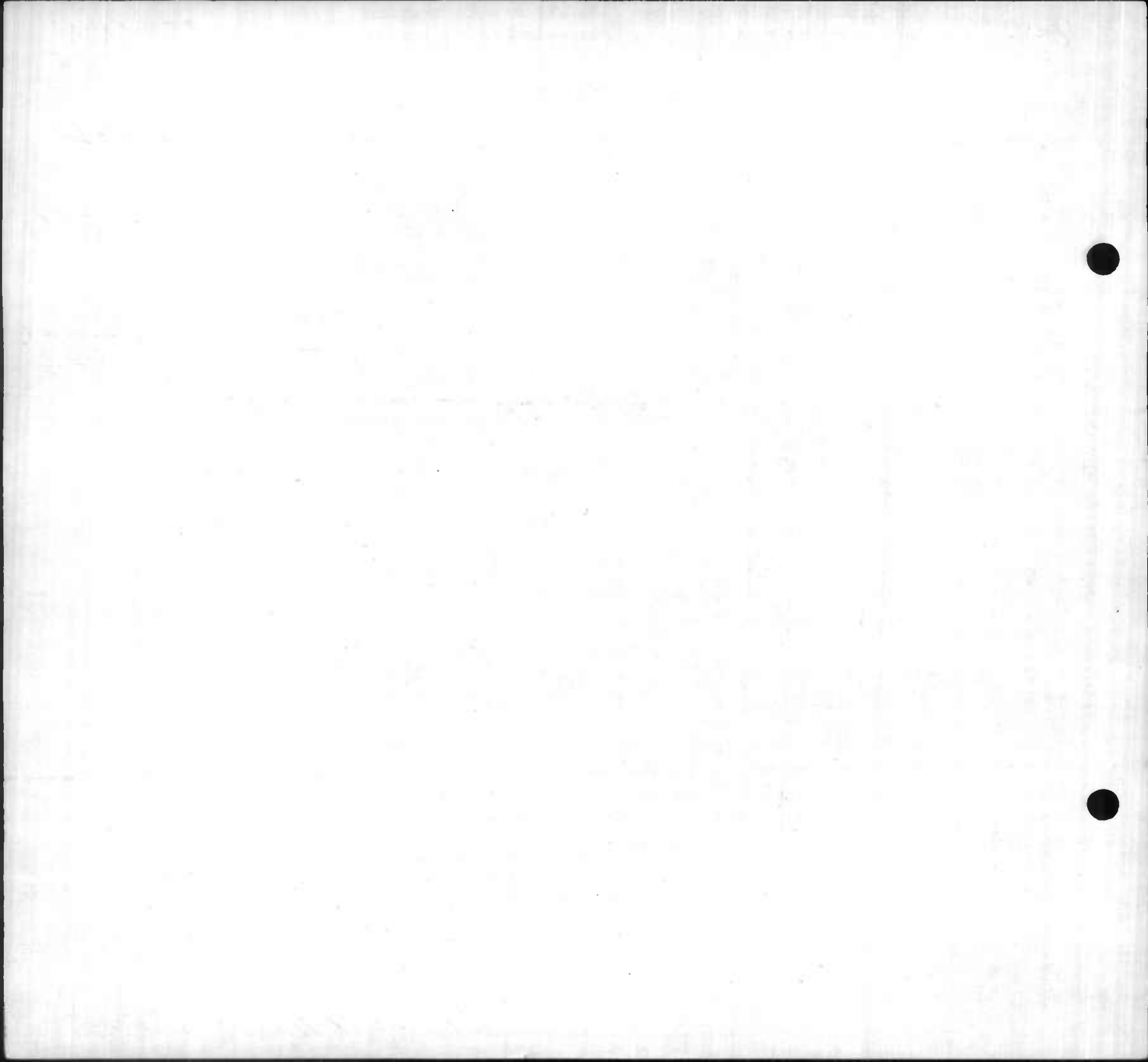
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|--|------------------------------------|---|--|--|--|--|---|--|--|-----------------------------------|--|
| BIRTH NO. 65 1433 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1433 | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Elsie Alma Parks | | | | | | | | | | 2/7/65 11:10 P.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 317 E. 29th St. | | | | | | | | | | A. STATE Md. B. COUNTY 12-03 | | | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 317 E. 29 St | | | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | | 8. DATE OF BIRTH 3/19/95 | | 9. AGE (In years last birthday) 69 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Va. | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Perry | | | | | | | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Family | | | | ADDRESS | | | | |
| 18. 1728 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) metastatic Carcinoma of endometrium | | | | | | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (A) DUE TO | | | | | | |
| | | | | | | | | | | (B) DUE TO | | | | | | |
| | | | | | | | | | | (C) DUE TO | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 1963</u> 19 <u>63</u> to <u>2/7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE  | | | | | | | | | | M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED <u>2/8/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) Samuel Rubin, M.D. | | | | | | | | | | 23D. ADDRESS 203 Patapsco Avenue Baltimore, Md. 21225 | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 2/11/65 | | 24C. NAME OF CEMETERY or CREMATORY Clarksburg, Cem. | | | | | 24D. LOCATION (City, town, or county) (State) Deltaville, Va. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | | | 25C. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco Ave. jhh | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

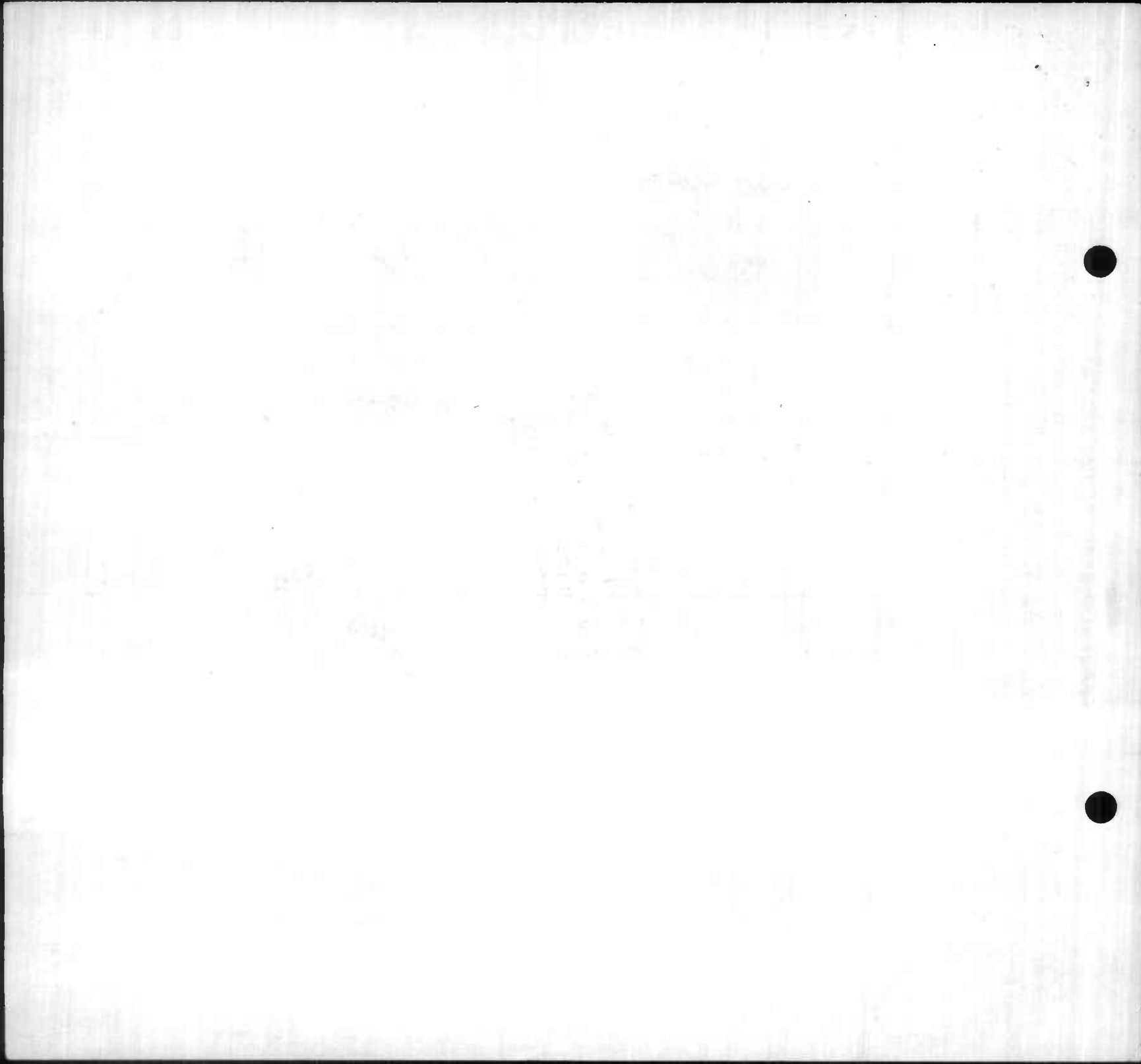
| | | | | | |
|--|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 65 1434 | | CERTIFICATE OF DEATH X | | Registered No. 65 1434 | |
| 1. NAME OF DECEASED (Type or Print) Elizabeth Leigh Hill | | 2. DATE AND HOUR OF DEATH February 21/65 3⁰⁵/A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Hospital For the Women of Maryland | | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE Md. B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 849 Park Ave. 52-00 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED (but separated) | 8. DATE OF BIRTH 10-20-19 | 9. AGE (In years last birthday) 45 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Delaware | |
| 13. FATHER'S NAME Joseph Roland LeGates | | 14. MOTHER'S MAIDEN NAME BURTON-ELVA DELMAR, DEL. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 222-05-7933 | | 17. INFORMANT Patients chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 200.01 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) GENERALIZED CARCINOMATOSIS DUE TO (B) RETICULUM CELL SARCOMA DUE TO (C) — | | INTERVAL BETWEEN ONSET AND DEATH — | |
| 19A. DATE OF OPERATION 09/30/64 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL MASS | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-2-1965 to 2-7-1965 , that (I) (we) last saw the deceased alive on 2-6-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jacques E. Rioux M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 2-7-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR J.K. OWEN | | 23D. ADDRESS 11 ELMWOOD ROAD, BALTIMORE, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burned | | 24B. DATE 2-10-65 | | 24C. NAME OF CEMETERY or CREMATORY St. Stephens | |
| 24D. LOCATION (City, town, or county) (State) Delmar, Del. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Charles H. Marnel, Delmar, Del. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

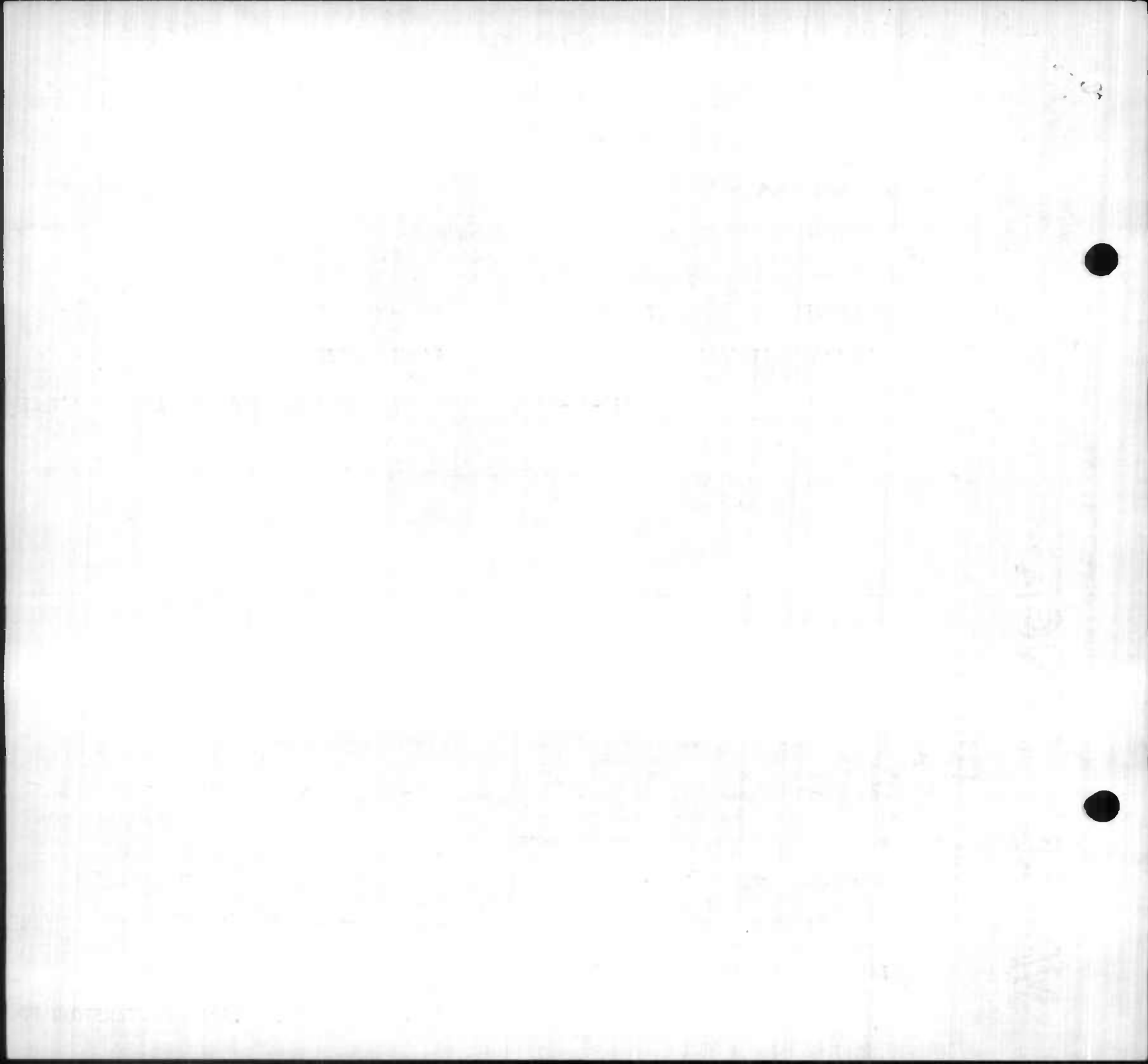
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1435 | | | | |
| BIRTH NO. 65 1435 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) WOLBERG, SAMUEL | | | | | 2. DATE AND HOUR OF DEATH 2/4/65 5:41 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital Calld. Md. | | | | | A. STATE Md | | | | |
| | | | | | B. COUNTY 2720 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3331 Clarks Lane CLARKS LANE | | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 9-10-1900 | 9. AGE (In year last birthday) 64 | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | | 10B. KIND OF BUSINESS OR INDUSTRY Furniture | | 11. BIRTHPLACE (City or foreign country) Milwaukee, Wisconsin | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME MAX Wolberg | | | | | 14. MOTHER'S MAIDEN NAME Rebecca ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. Kitty Wolberg | | | ADDRESS 3331 Clarks Lane | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | 20A. AUTOPSY Yes or No NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Lee E. Gresser | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 2-4-65 | |
| 23C. PHYSICIAN'S NAME (Type) Lee E. Gresser | | | | | 23D. ADDRESS Sinai Hospital of Balto. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/7/1965 | | 24C. NAME of CEMETERY or CREMATORY Mikro Kodesh - Beth Israel | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | | 25C. FUNERAL DIRECTOR Sol Levinson + Bros. Inc. 6010 Reisterstown Rd | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1436</u> | | | | |
| BIRTH NO. <u>65 1436</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>SARAH SHEARER</u> | | | | | 2. DATE AND HOUR OF DEATH <u>FEBRUARY 5, 1965</u> <u>5:00 A.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSP. OF BALTIMORE</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>13-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>603 WHITELOCK ST.</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>APRIL 4, 1890</u> | 9. AGE (In years last birthday) <u>74</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>ABRAHAM SWITHGALL</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>FANNIE KATZEN</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-12-6081</u> | | 17. INFORMANT <u>MISS HELEN SHEARER 600 WHITELOCK ST APT EE</u> | | | | | |
| 18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMATOSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ADENOCARCINOMA @ BREAST</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>LARGE BOWEL OBSTRUCTION</u> | | | | | CAUSE OF DEATH (A) <u>CARCINOMATOSIS</u> DUE TO (B) <u>ADENOCARCINOMA @ BREAST</u> DUE TO (C) <u>8 1/2 YRS</u> <u>1 1/2 MON.</u> | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>DEC. 24</u> 19 <u>64</u> to <u>FEB. 5</u> 19 <u>65</u> , that (H) (we) last saw the deceased alive on <u>FEB. 5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Melvin M. Friedman</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <u>2-5-65</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>MELVIN M. FRIEDMAN</u> | | | | | 23D. ADDRESS <u>Sinai Hosp. of Baltimore</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/7/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>SHAAREI TFILOH</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u> | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ABRAHAM FOOKSMAN

2. DATE AND HOUR PRONOUNCED DEAD

2-7-65

8:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BELVEDERE NURSING HOME - HOUSE OF THE PINES
WEST BELVEDERE AVENUE4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3314 Clarks Lane - Apt. "F"

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 27, 1899 65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Distributor

10B. KIND OF BUSINESS OR INDUSTRY

Maryland News Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Fooksman

14. MOTHER'S MAIDEN NAME

Anna SHERR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-03-2202

17. INFORMANT

ADDRESS

Mrs. Esther Fooksman, 3314 Clarks Lane

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple myeloma - atypical
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-8-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2/9/65

23C. NAME of CEMETERY or CREMATORY

BETH JACOB

23D. LOCATION

(City, town, or county)

(State)

FINKSBURG, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

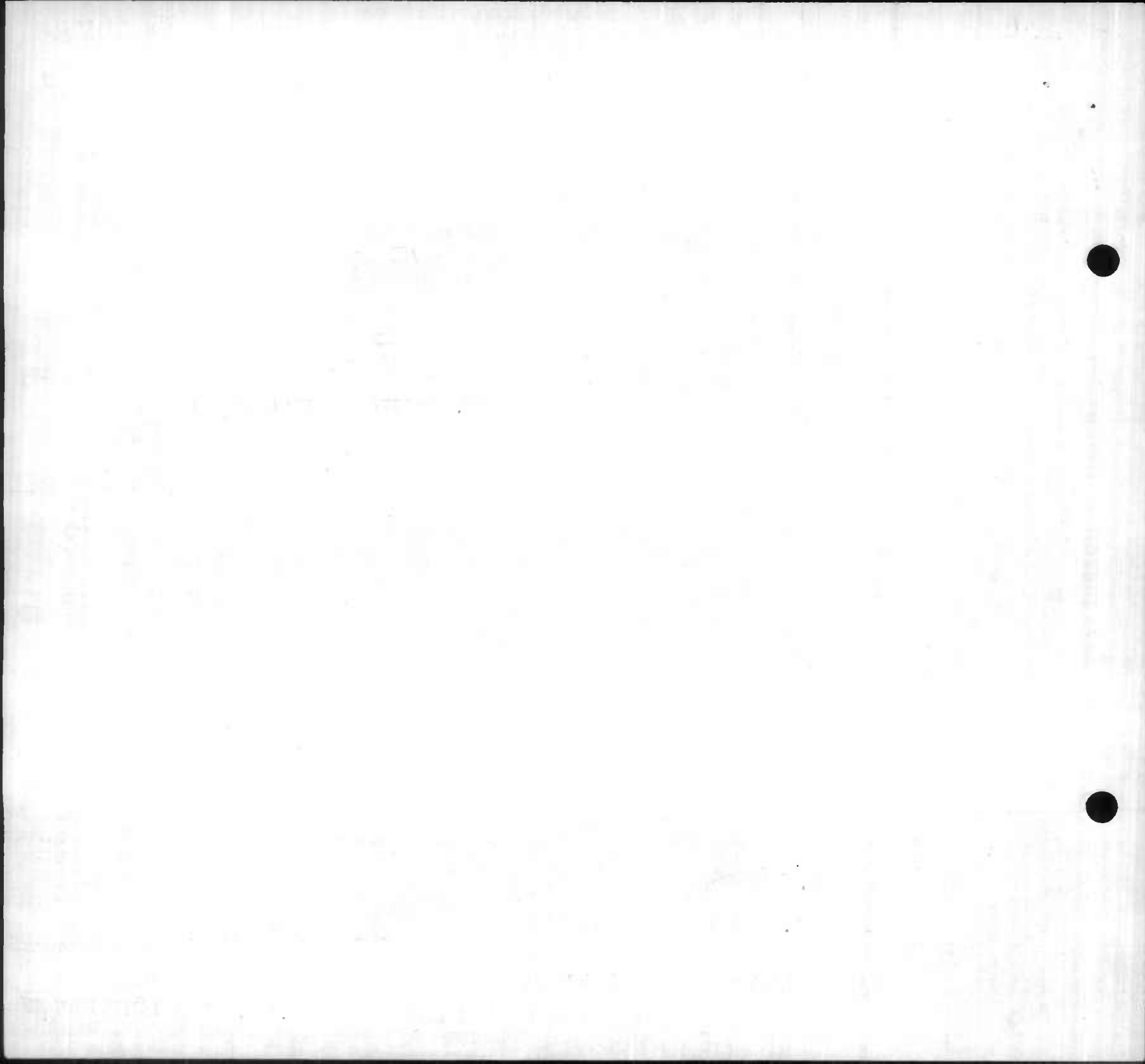
1.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1438 | |
|---|----------------------|---|---|--|---|
| BIRTH NO. 65 1438 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Fannie SHOR | | 2. DATE AND HOUR OF DEATH FEB. 8, 1965 1:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSP. | | A. STATE MARYLAND B. COUNTY 13-01 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 17 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2601 MADISON Ave | | | |
| 5. SEX FEMALE | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH SEPT. 15, 1897 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY AT Home | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Samuel Barshop | | | |
| 14. MOTHER'S MAIDEN NAME Zella GREENSPAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) not known | | | |
| 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS MRS. ANNETTE WEINTRAUB 3703 FALLSTAFF RD APT A | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 416X I | | CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) ATRIAL FIBRILLATION DUE TO (C) Intermittent Heart Block ? | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO! | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 26 19 65 to FEB 8 19 65 , that (I) (we) last saw the deceased alive on FEB 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE REUBEN C. GUERRERO | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/8/65 | |
| 23C. PHYSICIAN'S NAME (Type) REUBEN C. GUERRERO | | 23D. ADDRESS M.D. MONTEBELLO STATE HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/9/65 | | 24C. NAME OF CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1439 | |
|---|-----------------|--|-----------------------------|---|--|---|-----------------------|
| BIRTH NO. 65 1439 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) HARRY MONFRED | | | | 2. DATE AND HOUR OF DEATH 8 FEB 65 4 37 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3501 ST. PAUL ST. Apt 1024 | | | |
| 5. SEX Male | 6. RACE Cauc | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-24-08 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWS STAND OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY SALES | | 11. PLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME AARON MONFRED | | | | 14. MOTHER'S MAIDEN NAME DORA PAYMER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK N/A | | 16. SOCIAL SECURITY NO. UNK | | 17. INFORMANT MRS. FANNIE MONFRED | | ADDRESS #1024 3501 St. Paul St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) MYOCARDIAL INFARCTION (B) ARTERIOSCLEROSIS (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ANEMIA | | | | INTERVAL BETWEEN ONSET AND DEATH 36 HRS | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A | | 21F. HOW DID INJURY OCCUR? N/A | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 FEBRUARY 1965 to 8 FEBRUARY 1965, that (I) (we) last saw the deceased alive on 8 FEBRUARY 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Frederic O. Smith | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8 February 1965 | |
| 23C. PHYSICIAN'S NAME (Type) DR FRED SMITH | | | | 23D. ADDRESS M.D. Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/9/65 | | 24C. NAME OF CEMETERY or CREMATORY BETH TFILOH | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

475

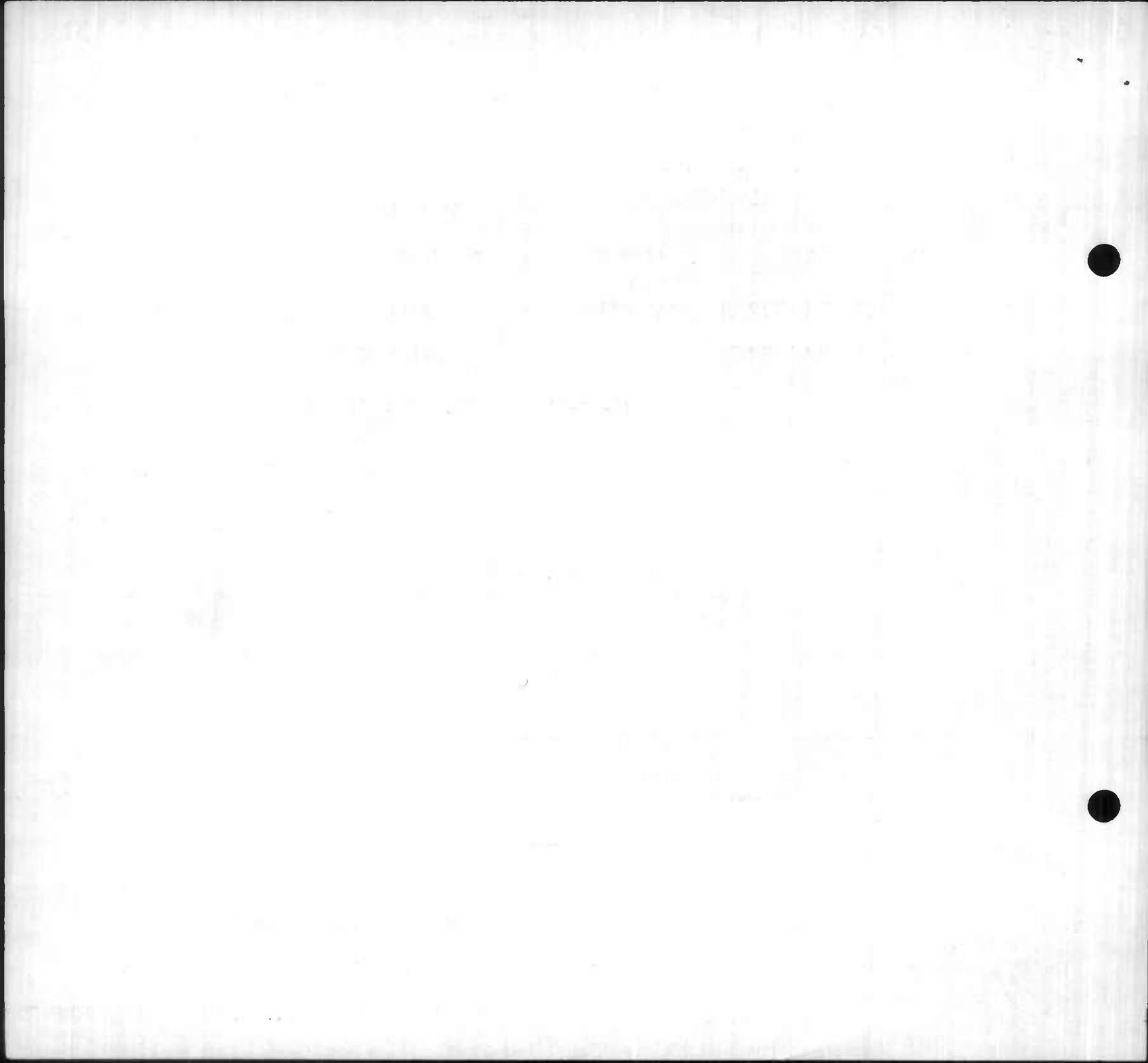
Supplies (C. 100) - 1000

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

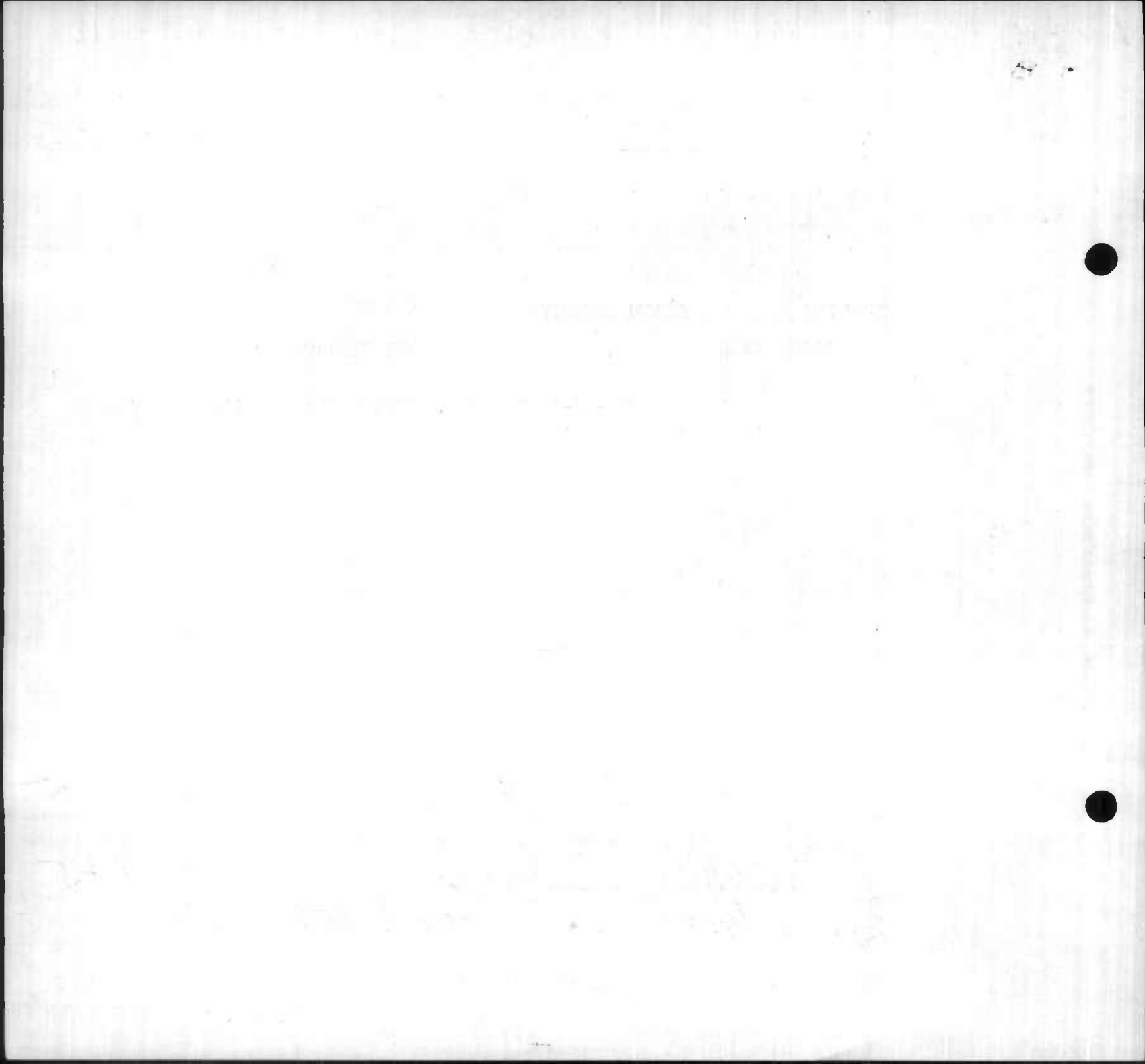
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|---|--|--|---|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1440 | | | | | |
| BIRTH NO. 65 1440 | | | | | 1. NAME OF DECEASED (Type or Print) MORRIS DINKIN | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARLENE GLEN APTS 3421 GLEN AVENUE | | | | | 2. DATE AND HOUR OF DEATH FEBRUARY 6, 1965 4³⁰ A.M. | | | | | |
| | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-19 | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3421 GLEN AVE (MARLENE GLEN APTS) | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/5/1888 | 9. AGE (In years last birthday) 76 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT (RETIRED) | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ABRAHAM DINKIN | | | 14. MOTHER'S MAIDEN NAME HILDA DIANE ? | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 215-01-4128 | | 17. INFORMANT MRS. NORMA FINEBLUM | | | | ADDRESS 2702 GEARTNER RD | |
| 18. 180x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | | | (A) Metastatic lung cancer DUE TO (B) Primary carcinoma of kidney DUE TO (C) | | | 1 year 2 years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1956 to Feb. 5, 1965 , that (I) (was) last saw the deceased alive on Feb. 5, 1965 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Sheldon C. Kravitz | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 2/6/65 | | |
| 23C. PHYSICIAN'S NAME (Type) SHELDON KRAVITZ | | | | | 23D. ADDRESS M.D. 6715 PARK HEIGHTS AVENUE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/7/65 | | 24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

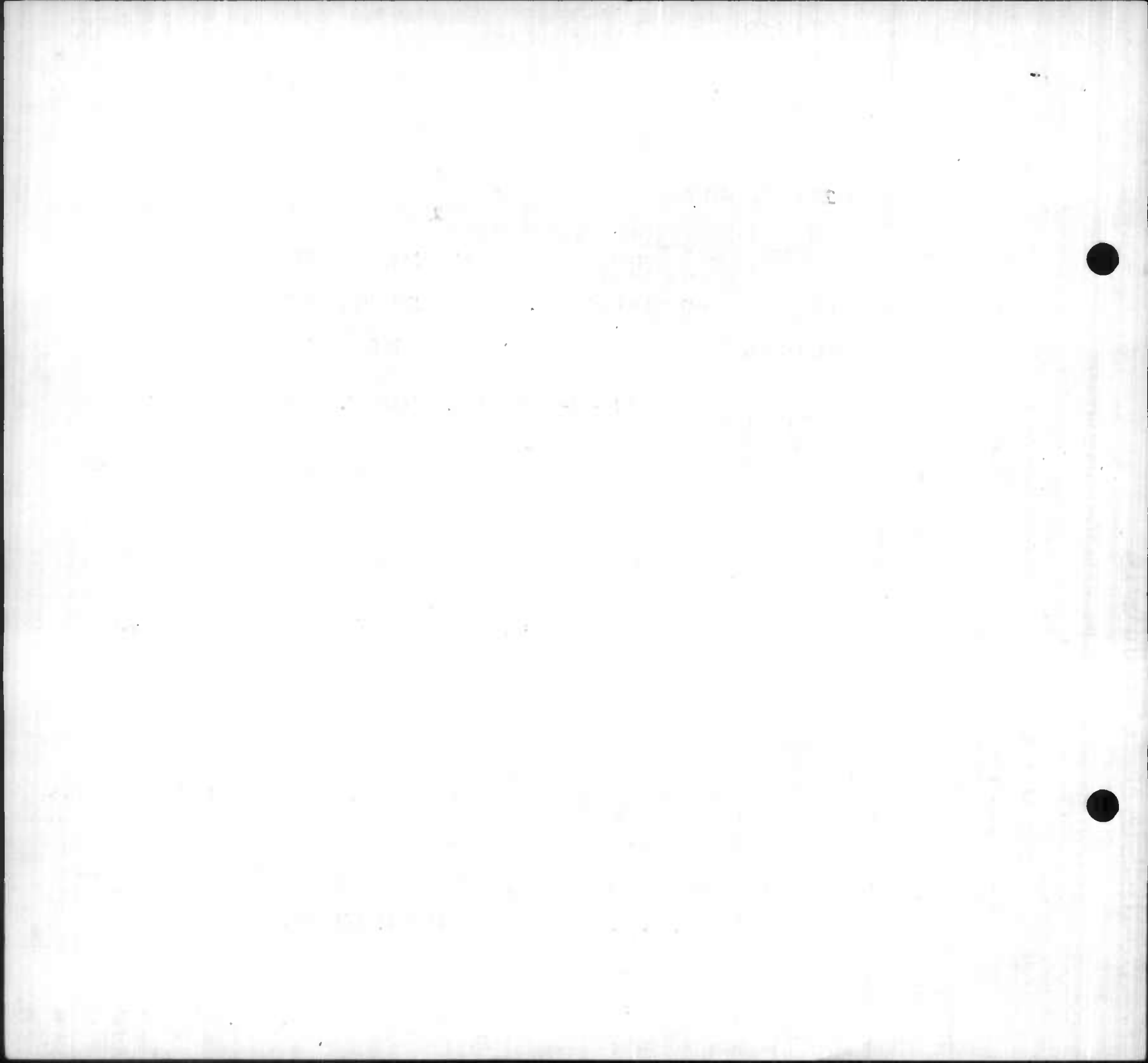
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 65 1441 | |
|---|-------------------------|---|-----------------------------------|--|--|--|-----------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. 65 1441 | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) NORMAN TAUBS | | | | 2. DATE AND HOUR OF DEATH 2/6/65 9:25 PM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT D. STREET ADDRESS (If rural, give location) 5115 PALL MALL RD | | | |
| 5. SEX MALE | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6/8/18 | 9. AGE (In years last birthday) 46 | If Under 1 Tr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPUTER | | 10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY | | 11. BIRTHPLACE (State or foreign country) NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOSEPH TAUB | | | | 14. MOTHER'S MAIDEN NAME ROSE FISHMAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES ARMY WW 2 | | 16. SOCIAL SECURITY NO. 084-01-6441 | | 17. INFORMANT MRS. DOROTHY TAUB | | ADDRESS 5115 PALL MALL RD | |
| 18. H20.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarct ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Acute myocardial infarct DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPST? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 1963 to FEBRUARY 1965 , that (I) we last saw the deceased alive on FEB. 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Rafael Perez-Mera M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-7-65 | |
| 23C. PHYSICIAN'S NAME (Type) RAFAEL PEREZ-MERA M.D. | | | | 23D. ADDRESS 7306 LIBERTY RD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SEARD | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

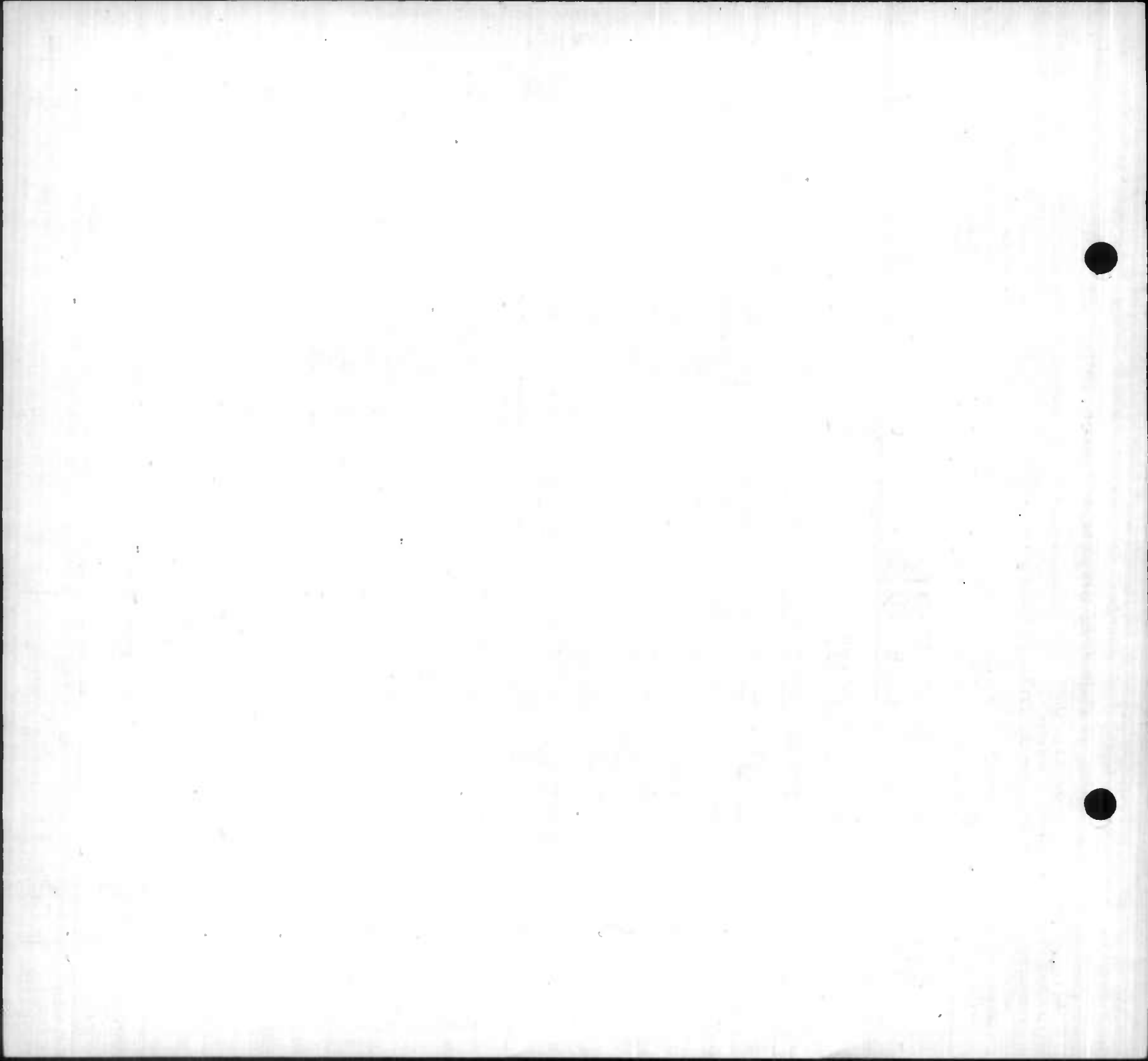
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decedent was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1442 | |
|--|--|--|--|--|---|
| BIRTH NO. 65 1442 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) RALPH L. EPHRAIM | | 2. DATE AND HOUR OF DEATH FEBRUARY 5, 1965 6:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2228 LINDEN AVENUE | | A. STATE MARYLAND | | | |
| | | B. COUNTY 13-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2228 LINDEN AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 5/30/1887 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY HAT MANUFACTURER | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ISAAC EPHRAIM | | 14. MOTHER'S MAIDEN NAME ESTHER ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-01-2496 | | 17. INFORMANT ADDRESS MRS. MILTON J. HAAS 2408 KEN OAK ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 331X + 177X | | CAUSE OF DEATH (A) Cerebro-Vascular Acc DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 mo | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Carcinoma Prostate | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 19 2/5 19 65 , that (I) (we) last saw the deceased alive on 2/5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edward A. Kallins | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/6/65 | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD KALLINS, M. D. | | 23D. ADDRESS 4300 LIBERTY HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 2/7/65 | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS \$OL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1443 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 1443 | |
|--|------------------|--|-----------------------------|--|---|--|--|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | MUGOWSKI, CHARLES (KAZIMIERZ) | | February 5, 1965 | | 9:55 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | | | A. STATE Md. | | B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 6 27-01 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 5210 Hilburn Avenue Hillburn | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/15/01 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| | | Chesapeake Shoe Mfg. | | Poland | | USA | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| MUGOWSKI | | | | UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 213-03-6729 | | JOHN MUGOWSKI 836 N. CHESTER ST | | | |
| 18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | (A) Pulmonary emphysema and carcinoma of esophagus. | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 3 19 65 to Feb. 5 19 65 | | | | that (I) (we) last saw the deceased alive on Feb. 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | | |
| William B. VandeGrift | | | | | | February 6, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| William B. VandeGrift | | | | M.D. 1400 N. Caroline St. Balto. 21213 Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| BURIAL | | 2-9-1965 | | HOLY ROSARY CEM. PUNDA LK | | MD | | | |
| 25A. DATE RECD BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| FEB 9 1965 | | Robert E. Farley, M.D. | | JOHN M. WEBER & SONS INC. 401 S. CHESTER ST | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 1444 | |
|--|---------------------|--|-------------------------------------|---|---|
| BIRTH NO. 65 1444 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>WEAVER, BOIA E</i> | |
| 2. DATE AND HOUR OF DEATH <i>2/7/65</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-10</i> C. CITY OR TOWN <i>Baltimore</i> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <i>3907 Gold Spring Lane WEST.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>Cauc</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | B. DATE OF BIRTH <i>Nov 23 1892</i> | 8. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Balto Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>John Henry Skores</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah Rebecca Tyler</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>214-22-0562</i> | | 17. INFORMANT ADDRESS <i>John Milton Weaver</i> | |
| 18. <i>433.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Cardiac Arrhythmia</i> DUE TO (B) <i>A.S.C.V.D.</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>10 + yrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Idiopathic Pancytopenia, Pneumonia, Hemorrhagic Gastritis</i> | | 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that <i>Mr</i> (this hospital) attended the deceased from <i>2/6</i> 19 <i>65</i> to <i>2/7</i> 19 <i>65</i> , that <i>Mr</i> (we) last saw the deceased alive on <i>2/7</i> 19 <i>65</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <i>Marvin L. Ginsburg</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>2/7/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MARVIN L. GINSBURG</i> | | M.D. 23D. ADDRESS <i>SINAI HOSP. Baltimore</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | |
| 24B. DATE <i>Feb 11/1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>London Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Nancy J. Amico 4204 Ridgewood Ave</i> | |

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111

Handwritten text at the bottom of the page, possibly a signature or a date. The text is very faint and mostly illegible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

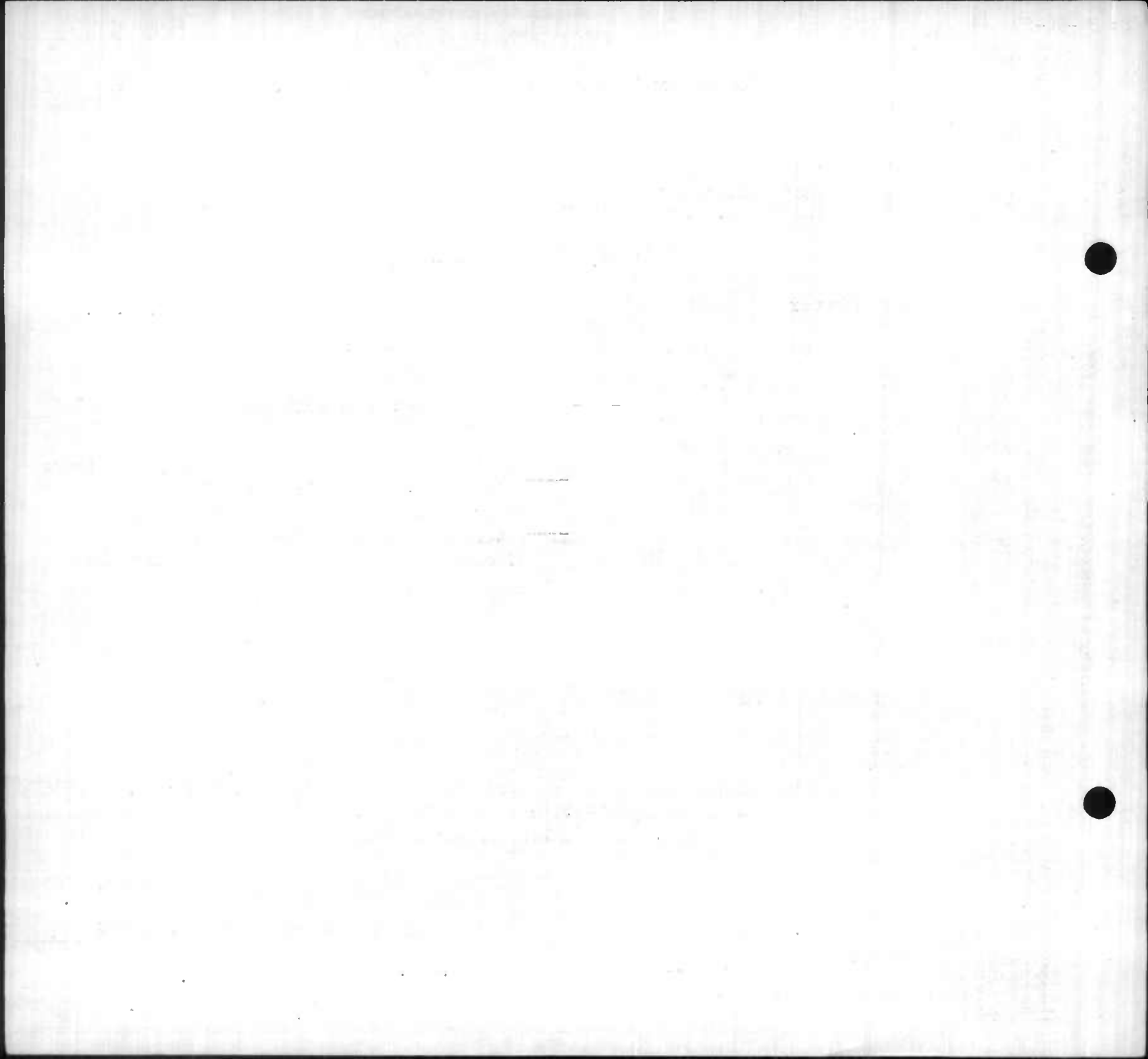
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|---------------|--|--|--|--------------------------------|---|------------------------------------|--|---|--|-----------------------|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1445 | | | | | | | | | | | | | | |
| BIRTH NO. 65 1445 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Mathew R. Wilman | | | | | 2. DATE AND HOUR OF DEATH Feb. 5, 1965 6:50 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE Maryland B. COUNTY Baltimore | | | | | | | | | | | | | | |
| Baltimore City Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sparrows Point | | | | | | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | 1330 Forrest Road | | | | | | | | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH March 5, 1895 | | 9. AGE (In years last birthday) 69 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Bethlehem Steel Co. | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Finland | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME Herman Wilman | | | | | 14. MOTHER'S MAIDEN NAME Sanalisa Wilman | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No | | | | | 16. SOCIAL SECURITY NO. 213-07-2516 | | 17. INFORMANT ADDRESS Wife, Elvira Wilman, # 4,a,b,c,d. | | | | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Cardiac Failure DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos 15 yrs ± | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) NO | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Feb 5 1965, that (I) (we) last saw the deceased alive on Feb 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE  M.D. | | | | | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED Feb. 6 1965 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Roger Windsor | | | | | | | | | | 23D. ADDRESS M.D. 520 D Street, Sparrows Point Md. 21219 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 2-8-1965 | | | | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | | | | | 24D. LOCATION (City, town, or county) (State) Trumps Mill Rd. Bal. Co. Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | | | | 25C. FUNERAL DIRECTOR John J. Duda | | | | | ADDRESS 7922 Wise Ave. Md. 21222 | | | | |

[Faint handwritten notes and signatures are visible across the page.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

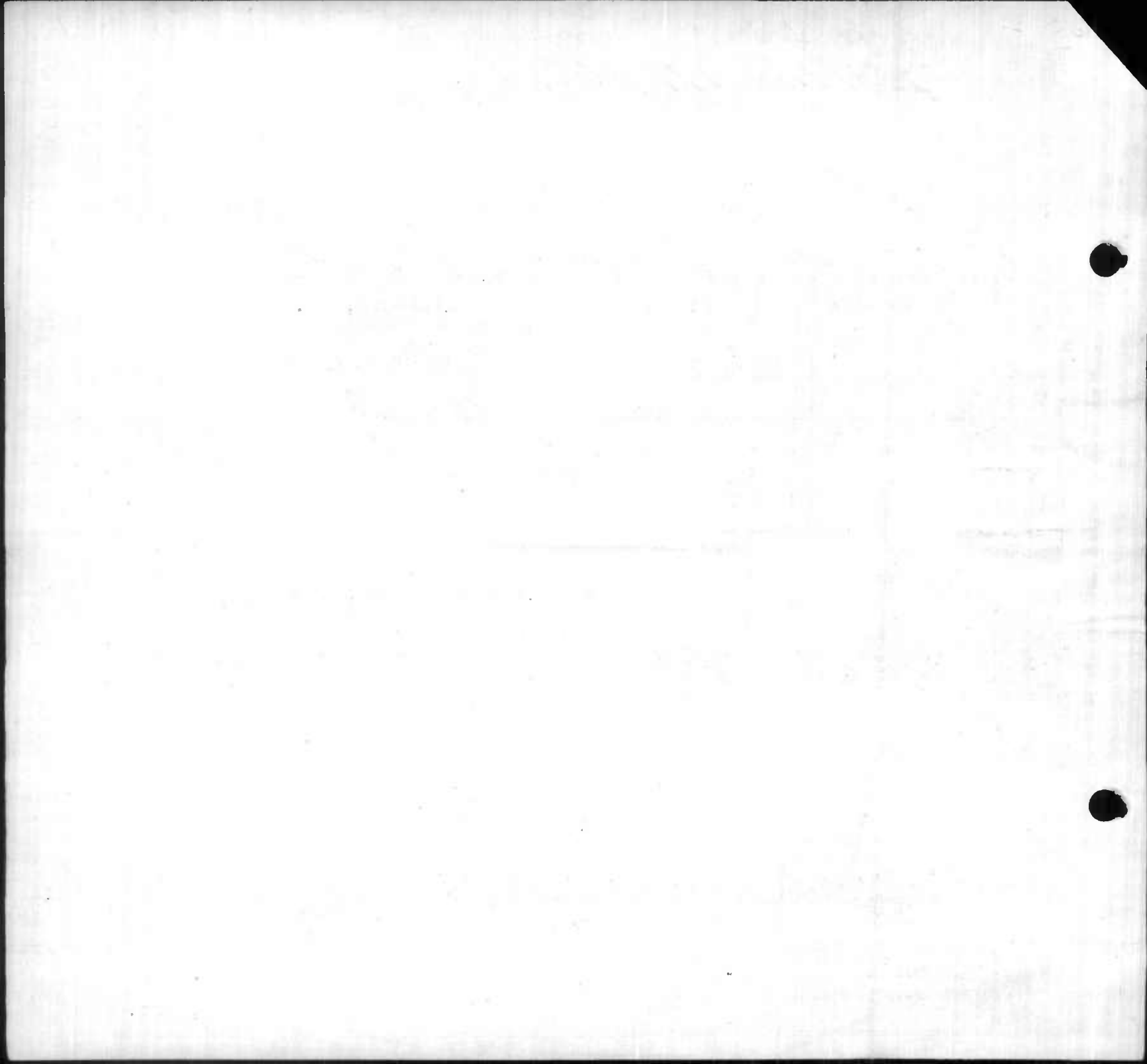
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1446 | |
|---|------------------------|--|------------------|--|--|
| BIRTH NO. 65 1446 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | (Also known as) | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Joseph Ruzicka | | ROSE) | | February 8, 1965 6:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland | | 26-12 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 4940 Eastern Avenue #21224 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Widowed | 2-5-1882 | 83 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Steamfitter | | Mitchell Plumbing | | Baltimore Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Frank Ruzicka | | Anna Bielek | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 214-03-0310 | | RECORDS: BCH: 4940 Eastern Avenue #21224 | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) Septicemia | | About 48 Hours | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Urinary Tract Infection and Gangrene of (R) Leg | | About 1 Month | |
| | | (C) Arteriosclerotic Cardio-Vascular Disease | | Many Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 5, 1963 to February 8, 1965, that (I) (we) last saw the deceased alive on February 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| C. Robert Cooke | | | | February 8, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| C. Robert Cooke | | 4940 Eastern Avenue Baltimore, #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 2/11/65 | Holy Redeemer Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 9 1965 | Robert E. Farley, M.D. | Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

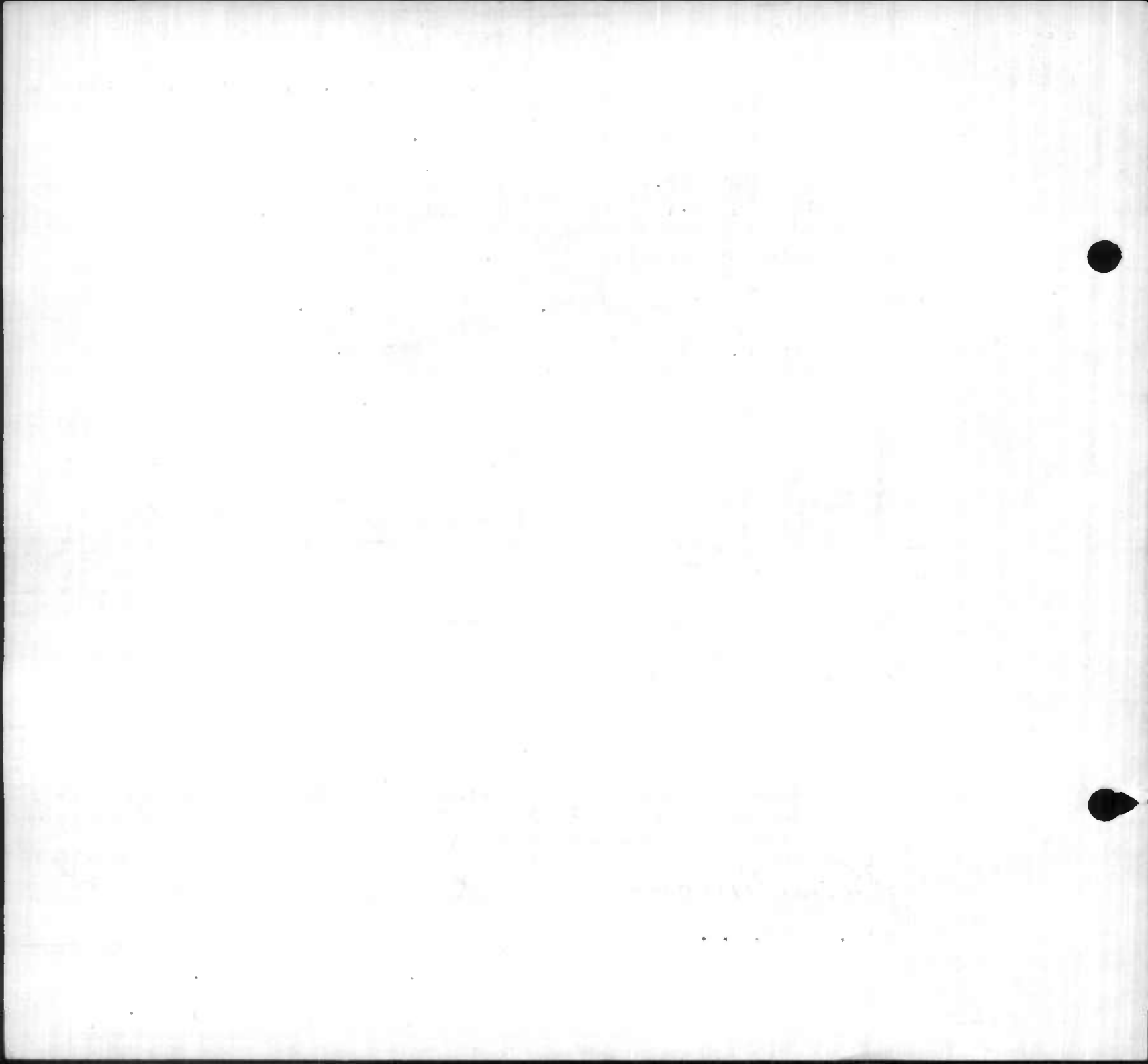
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1447 | |
|---|----------------------|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1447 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Barbara M. Herring</i> | | | 2. DATE AND HOUR OF DEATH <i>Feb 7, 1965 11:19A</i> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Womans Hospital Baltimore 17, Md</i> | | | A. STATE <i>Md</i> B. COUNTY <i>2603</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| D. STREET ADDRESS (If rural, give location) <i>3007 Reetucky Ave - 13</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W.</i> | 7. MARRIED, NEVER-MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>1/9/97</i> | 9. AGE (In years lost birthday) <i>68</i> | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | |
| 13. FATHER'S NAME <i>Peter Losenberg</i> | | | 14. MOTHER'S MAIDEN NAME <i>Wieler Catherine Wyer</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Pts. Chart</i> ADDRESS | |
| 18. <i>584X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH <i>Nephritis with uremia 6 mos</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cholelithiasis, Sarcosis & Metastatic disease</i> | | | | | |
| 19A. DATE OF OPERATION <i>2/5/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i> | | 20A. AUTOPSY (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/3/65</i> to <i>2/7/65</i> , that (I) (we) lost saw the deceased alive on <i>2/7</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>2/7/65</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>John K. Owen</i> | | | 23D. ADDRESS <i>104 W. Madison St</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/11/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> ADDRESS <i>3331 Brehms Lane</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|----------------------|--|----------------------------|---|--|
| BIRTH NO. 65 1448 | | CERTIFICATE OF DEATH | | 65 1448 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | DOROTHY MARGARET ARIGO | | Feb. 7, 1965 7:45 a M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3714 Elmley Ave., Baltimore, Md., 21213 | | A. STATE Md. B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3714 Elmley Ave. | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 5/7/15 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | 10B. KIND OF BUSINESS OR INDUSTRY Eddie Super Mkt. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME Walter J. Belt | | 14. MOTHER'S MAIDEN NAME Mary E. Wehn | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Anthony P. Arigo, husband, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X I CAUSE OF DEATH (A) Carcinomatous DUE TO (B) Carcinoma of left breast DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 mo 1 yr. | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | |
| 19A. DATE OF OPERATION 11-64 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of breast | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 1964 to February 7, 1965, that (I) (we) last saw the deceased alive on 2-5-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. J. Moore | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-8-65 | |
| 23C. PHYSICIAN'S NAME (Type) Duer J. Moores, M.D. | | 23D. ADDRESS M.D. 3105 Belair Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/10/65 | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



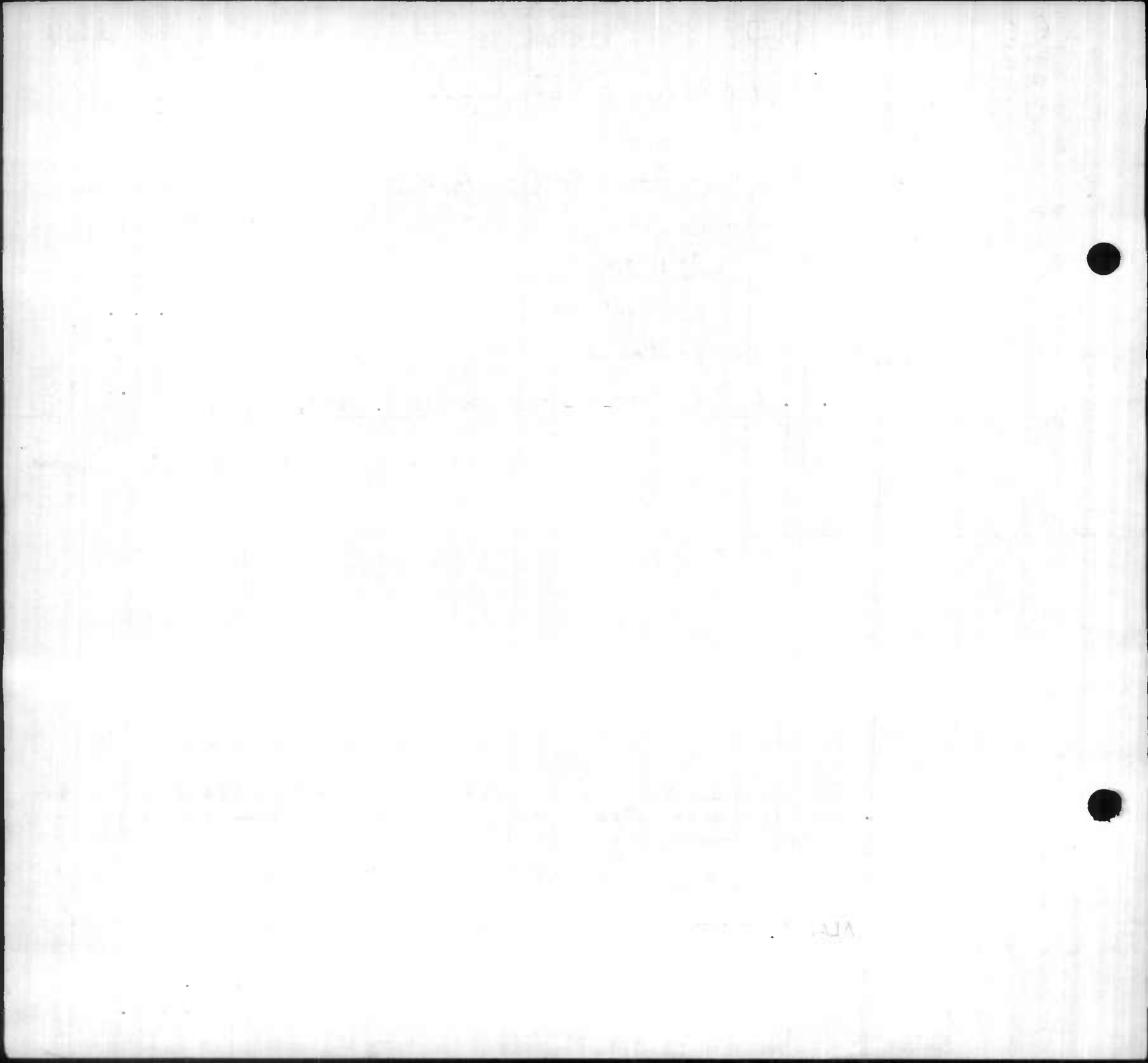
B-663

44

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|---|--|-------------------------|--|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1449 | | | | |
| BIRTH NO. 65 1449 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MR. FRANK BERARDOZZI | | | | | 2. DATE AND HOUR OF DEATH 2-7-65 5:15 PM | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | | | A. STATE Md. 8-01 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 2804 Erdman Ave | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 4/2/89 | | 9. AGE (In years last birthday) 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern | | 10B. KIND OF BUSINESS OR INDUSTRY Own Business | | 11. BIRTHPLACE (State or foreign country) Italy | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME DOMINIC Berardozzi | | | | | 14. MOTHER'S MAIDEN NAME Jeannie Ann Toni | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W. W. I | | | | | 16. SOCIAL SECURITY NO. 217-32-8753 | | 17. INFORMANT ADDRESS Carrie C. Kerr, friend, 3411 Woodstock Ave., #13 | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Acute myocardial Infarct. 36 hrs. | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 6 1965 to Feb 7 1965, that (I) (we) last saw the deceased alive on Feb 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Alan B. Cohen | | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 2/7/65 | |
| 23C. PHYSICIAN'S NAME (Type) ALAN B. COHEN | | | | | 23D. ADDRESS M.D. Union Memorial Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/11/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | | |



1
c-462
35

65 1450

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 1450

BIRTH NO.
M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) **GEORGE D. CLARK, JR.**

2. DATE AND HOUR PRONOUNCED DEAD
2/5/65 7:25 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
17 N. Washington St.

5. SEX **male**

6. RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH
4/21/22

9. AGE (In years last birthday)
42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
VIRGINIA

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME
GEORGE CLARK

14. MOTHER'S MAIDEN NAME
MABLE BOGGS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
YES WW II

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
ETHEL GOADE BALTO., MD.

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
(A) DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)
yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner H. Spitz** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **W.U. Spitz, M.D.** ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED
2/5/65

23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL

23B. DATE
1/8/65

23C. NAME of CEMETERY or CREMATORY
SHILOH CEMETERY

23D. LOCATION (City, town, or county) (State)
PULASKI CO., VIRGINIA

24A. DATE REC'D BY HEALTH DEPT.
FEB 9 1965

24B. NAME OF REGISTRAR
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR
HOWARD H. HUBBARD FUNERAL HOME

ADDRESS
4107 WILKENS AVE.

WALLACE

WALLACE

WALLACE

WALLACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 1451

BIRTH NO. 65 1451

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joshua Talbott

2. DATE AND HOUR OF DEATH

2/5/65

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Md

1606

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

829 N. Franklin town Rd

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

Oct 25, 1887

9. AGE (in years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Paper Hanger

10B. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

? Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joshua Talbott

14. MOTHER'S MAIDEN NAME

? Cora France

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No?

16. SOCIAL
SECURITY NO.

217-07-7677

17. INFORMANT

Mr. WILLIAM F. TALBOTT-829 Franklinton Rd-16

ADDRESS

18.

527.1 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Respiratory Failure

(B) DUE TO

Chronic Emphysema

(C)

INTERVAL BETWEEN
ONSET AND DEATH

indefinite

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0 NONE

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

NO

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work

Not While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/5/65 19 to 2/5/65 19
that (I) (we) last saw the deceased alive on 2/5/65 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry H. Boldman; Lindenstruth

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

2/5/65

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-9-65

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

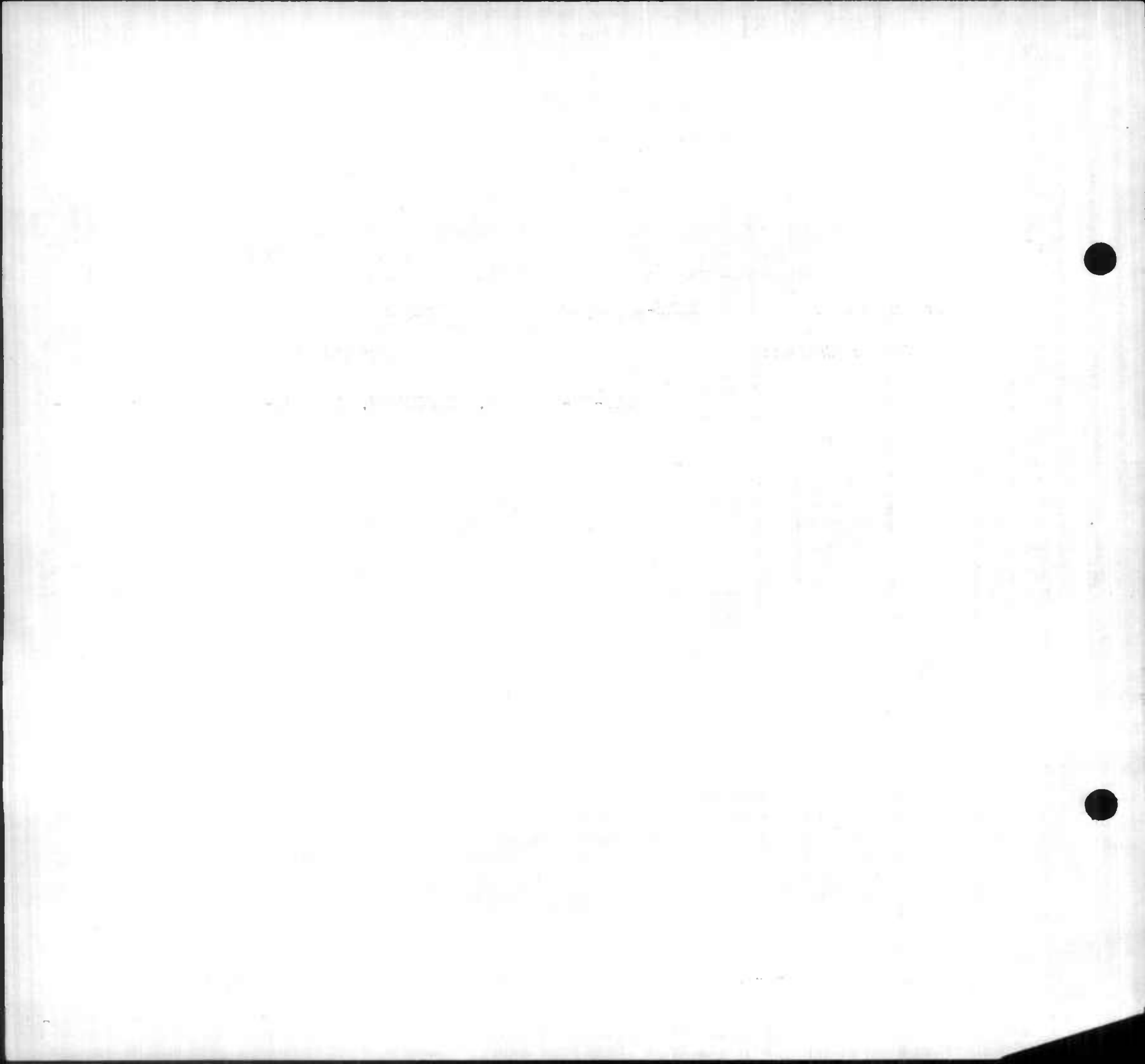
25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

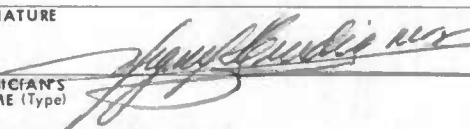
H. H. Hubbard 4107 W. Lake Ave-29

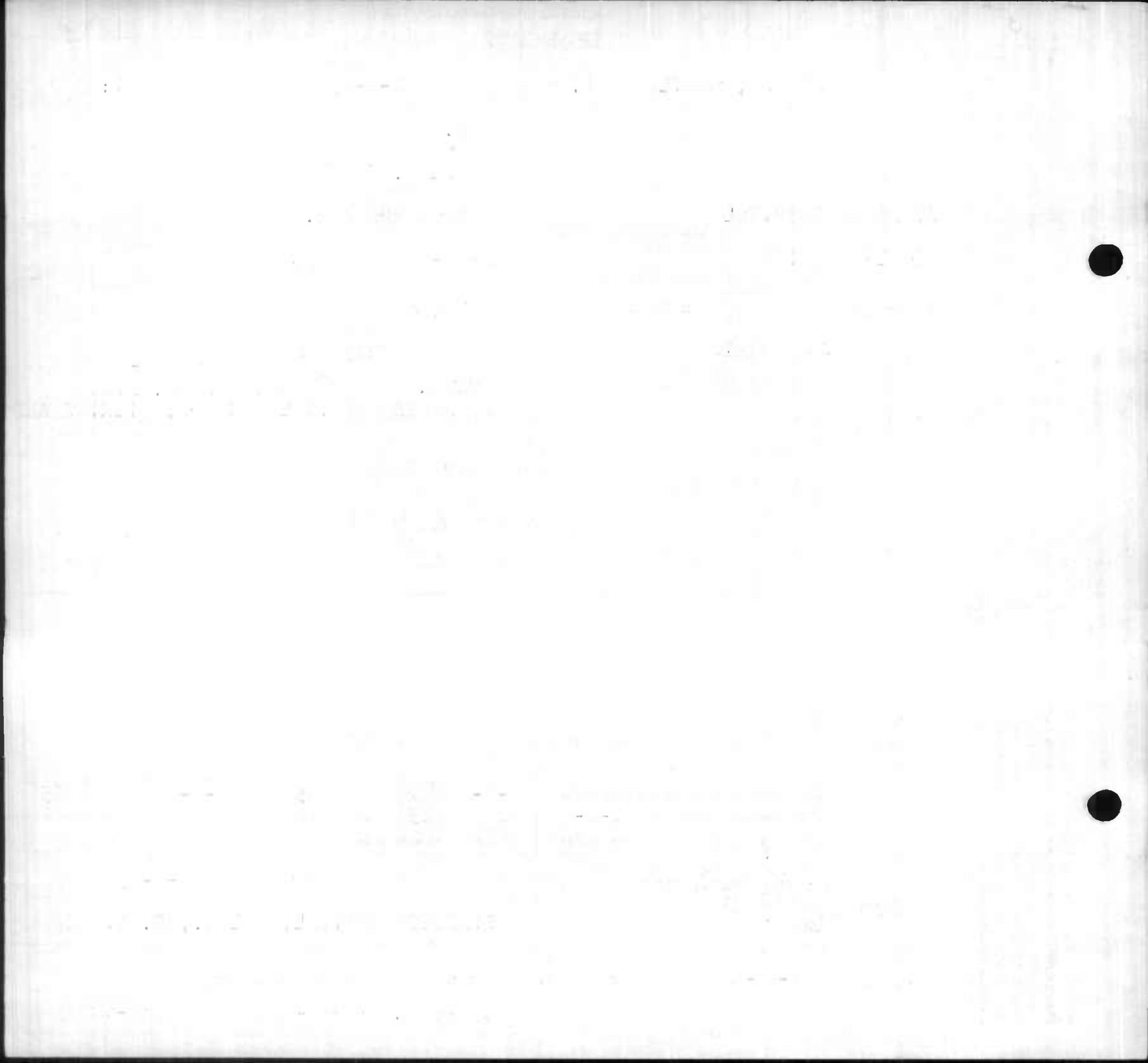
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | |
|--|-------------------------|---|--|--|--|---|------------------------------|---|--|
| BIRTH NO. 65 1452 | | Registered No. 65 1452 | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ASHMAN, MYRTLE H. | | | | 2. DATE AND HOUR OF DEATH 2-6-65 1:25 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL | | | | A. STATE MD. | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 21227 LANSDOWNE | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2008 2ND AVE. 53-00 | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 5-10-09 | | 9. AGE (In years last birthday) 55 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME John Harold | | | | 14. MOTHER'S MAIDEN NAME Mary Litz | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MARTIN P. ASHMAN | | | |
| | | | | ADDRESS 208 Second Avenue - 21227 CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND | | | | | |
| 18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Circulation of uterus | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6- 19 65 to 2-6- 19 65 , that (I) (we) last saw the deceased alive on 2-6- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-6-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) MARTIN P. ASHMAN | | | | 23D. ADDRESS STAGNES HOSPITAL, BALTO., MD. 21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-10-65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **65 1453**

BIRTH NO. **65 1453**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CARROLL PROCTOR

2. DATE AND HOUR OF DEATH

2/7/65 6:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**PROVIDENT HOSPITAL
BALTO. 17, MD.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **MARYLAND**

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

105 NO. CARROLLTON AVE.

5. SEX

M

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

5/5/11

9. AGE (In years last birthday)

53

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Radiator Co.

11. BIRTHPLACE (State or foreign country)

S. C.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

LONNIE PROCTOR

14. MOTHER'S MAIDEN NAME

BETHINE KINSLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-10-0169

17. INFORMANT

WIFE

ADDRESS

LOIS PROCTOR 105 NO. CARROLLTON AVE

18. **598X I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **UREMIA**
DUE TO

ONE MONTH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) **NEPHROTIC SYNDROME**
DUE TO

2-3 YEARS

(C) **GLOMERULONEPHRITIS**

3 YEARS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

HYPERTENSIVE CARDIOVASCULAR DISEASE

3 YEARS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **Jan 21 1965** to **Feb 7 1965**, that (I) ~~last~~ last saw the deceased alive on **Feb 7 1965** and that in (my) ~~last~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~did~~ ^{did not} view the body after death.

23A. SIGNATURE

Roland T. Smoot

M.D.

Attending Phys.

☒

Med. Director

☐

Staff Phys.

☐

23B. DATE SIGNED

2/7/65

23C. PHYSICIAN'S NAME (Type)

ROLAND T. SMOOT

23D. ADDRESS

M.D.

3817 COWLEY RD., BALTO. 18, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-10-65

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

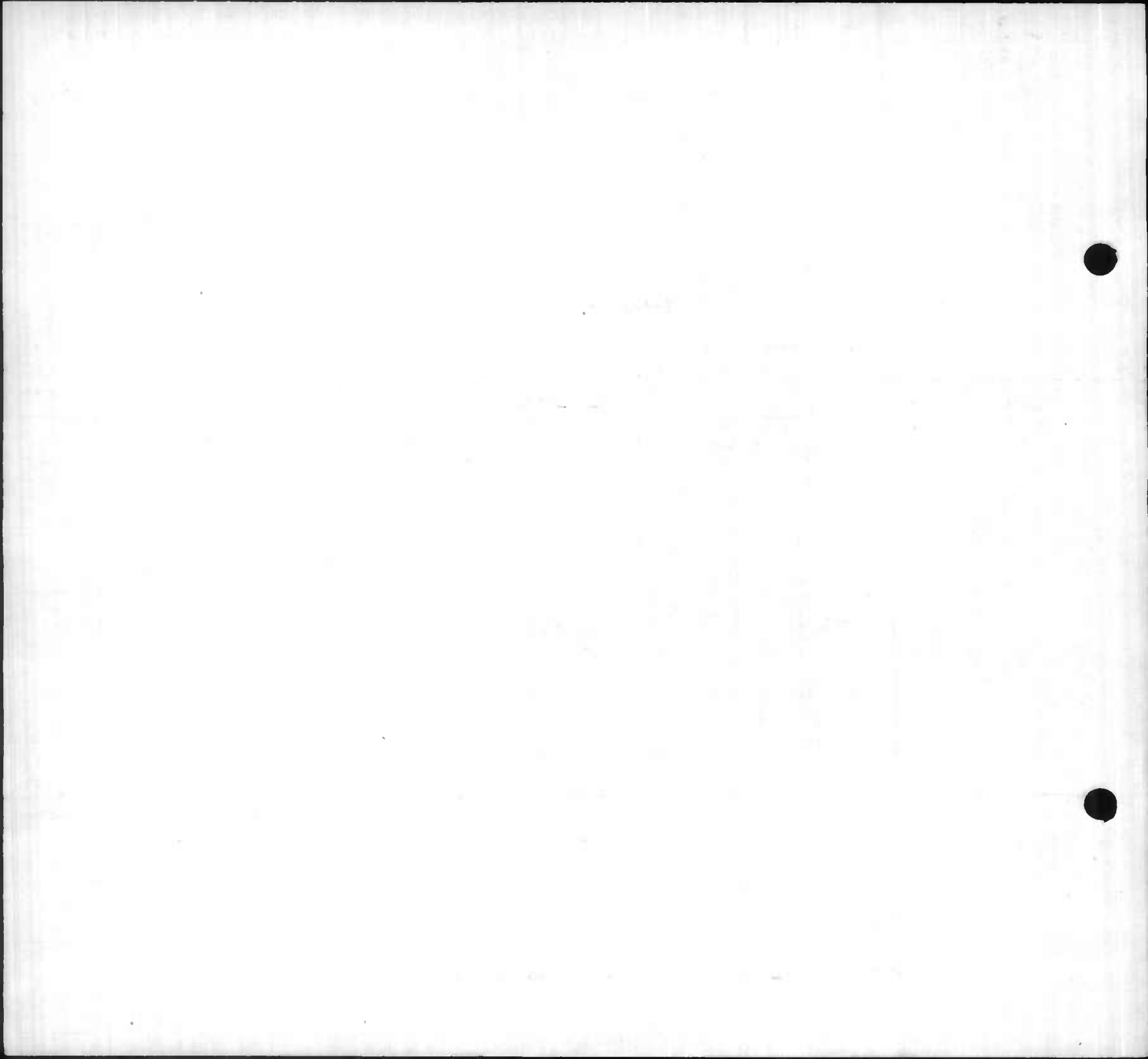
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

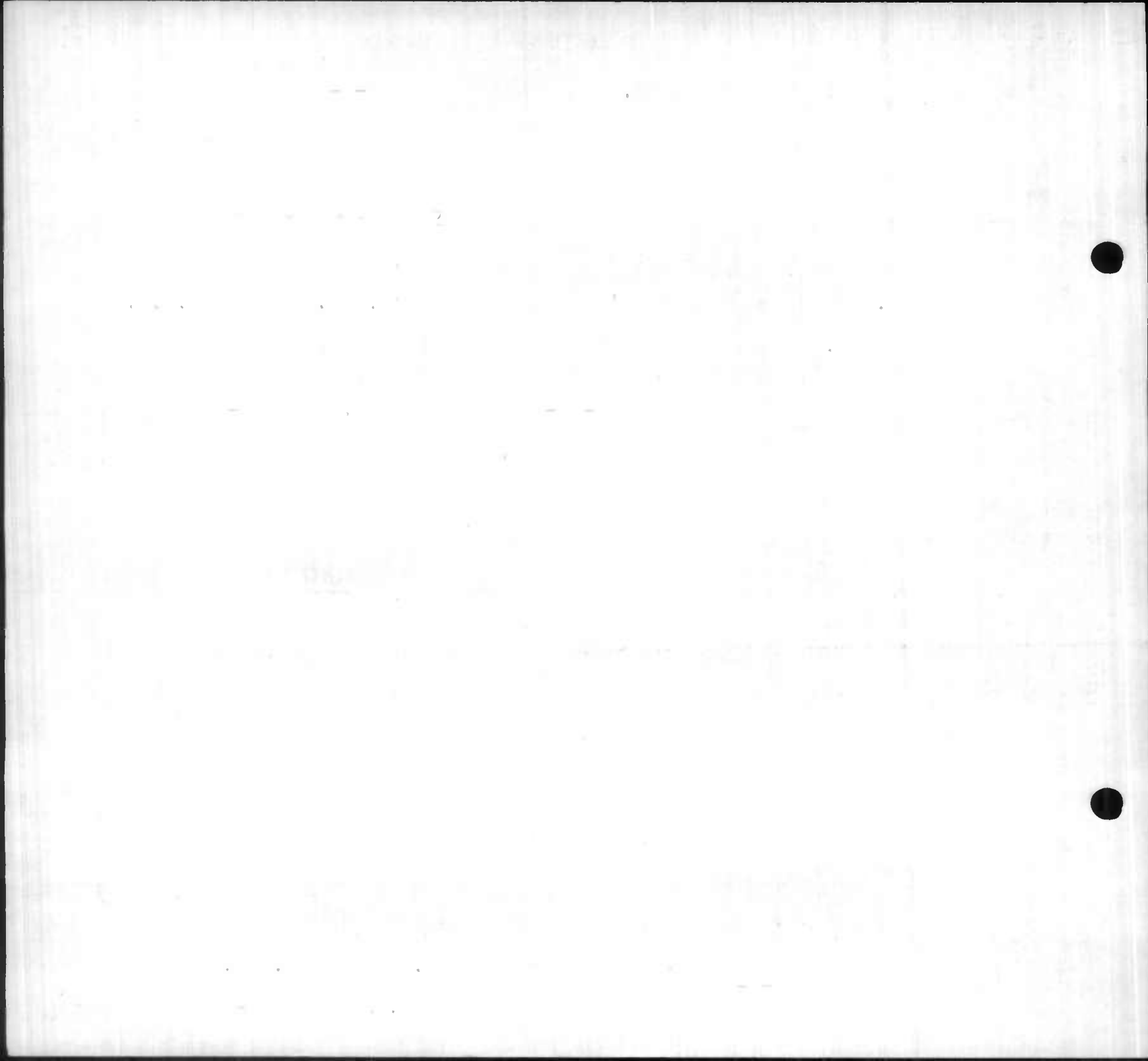
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1454 | |
|---|------------------|---|---|--|---|
| BIRTH NO. 65 1454 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) William Schott Sr. | | | 2. DATE AND HOUR OF DEATH 2-4-65 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2419 Pelham Avenue | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2419 Pelham Avenue | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 17, 1904 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asstn. Treasurer | | 10B. KIND OF BUSINESS OR INDUSTRY Citizen's Savings Bank | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Herman D. Schott | | | 14. MOTHER'S MAIDEN NAME Marie Arendt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-03-1186 | | 17. INFORMANT Dorothy M. Schott - Same | |
| 18. 334X + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Cerebral Arteriosclerosis DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10 YRS. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Diabetes Mellitus | | 2 YRS. |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 15, 1946 to 2/4, 1965, that (I) (we) last saw the deceased alive on 2/4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert J. Himefarrb | | | | 23B. DATE SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) Albert J. Himefarrb | | | | 23D. ADDRESS 3501 ST. PAUL ST | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-8-65 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR John G. Miller Inc-6415 Belair Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|-----------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1455 | | | | |
| BIRTH NO. 65 1455 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) William Weishaar | | | | 2. DATE AND HOUR OF DEATH February 6, 1965 7:50 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND , B. COUNTY CARROLL C. CITY OR TOWN (If outside city limits, write RURAL and give township) DETOUR D. STREET ADDRESS (If rural, give location) RT. # 1 | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 11-3-14 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10B. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME WILLIAM F. WEISHAAR | | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX Clara Starnier | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-12-2093 | | 17. INFORMANT ADDRESS LARRY WEISHAAR RFD, TANEYTOWN, MD. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 445X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastrointestinal hemorrhage | | | | CAUSE OF DEATH (A) DUE TO II remia (B) DUE TO Renal Shut Down + Oliguria (C) DUE TO Malignant Hypertension | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks few Months 3 weeks | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from Jan. 23 1965 to February 6 1965 , that the (we) last saw the deceased alive on February 6 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE L.J. Buckels M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/6/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) L.J. Buckels M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital - Baltimore, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-10-65 | | 24C. NAME OF CEMETERY OR CREMATORY Middleburg Methodist Cemetery | | 24D. LOCATION (City, town, or county) (State) Middleburg, CARROLL Co., MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR John M. Skiles C.O. Fyass & SON TANEYTOWN, MD. | | | | | |

15 MAR 1954

15 MAR 1954

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15 MAR 1954

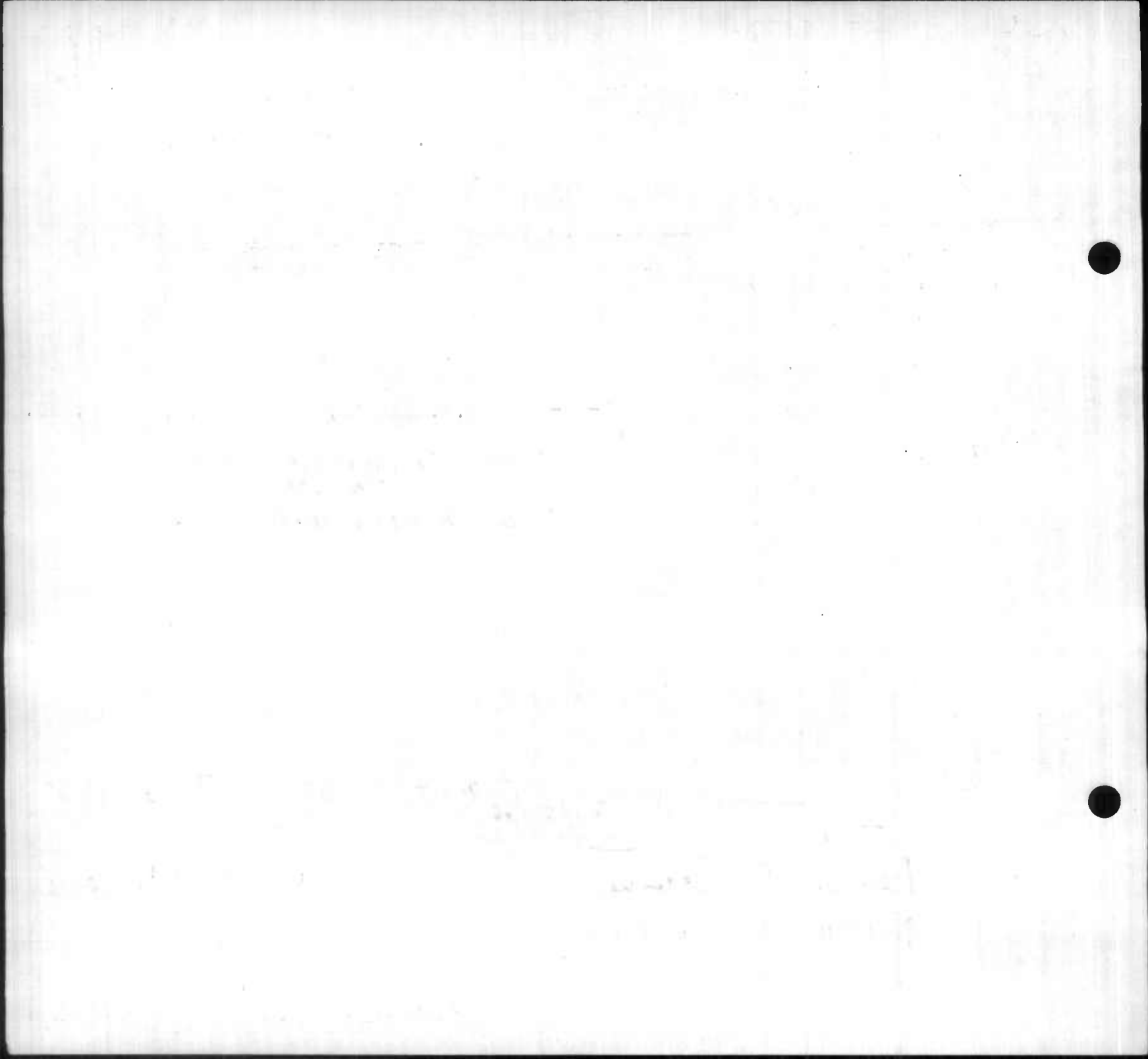
15 MAR 1954

15 MAR 1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

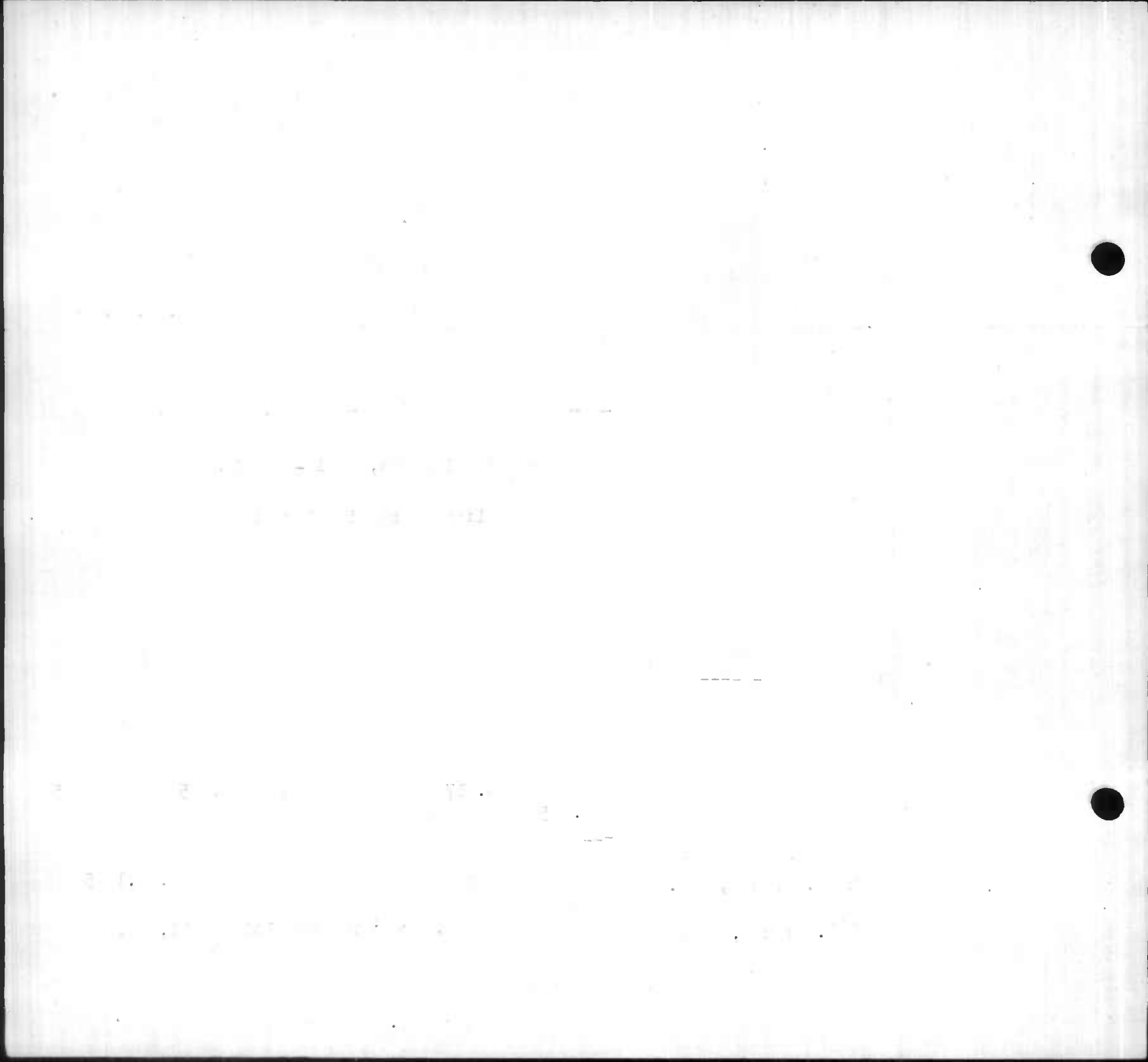
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1456 | |
|---|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 65 1456 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. Laffer Anna | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Anna Adele Daffin</u> | | 2. DATE AND HOUR OF DEATH <u>2/6/65</u> <u>7 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN Hosp. of Md.</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balro. Md.</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>3926 Kimble Rd</u> | | | |
| 5. SEX <u>FE</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>3/9/1911</u> | 9. AGE (In years last birthday) <u>53</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>RE Perry F. Daffin</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Wootres</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-20-9720</u> | | 17. INFORMANT <u>P.F. Daffin, Tunis Mills, Easton, Md.</u> | |
| 18. <u>253X I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) <u>SEVERE CONGESTIVE HEART FAILURE</u> | | | |
| ANTECEDENT CAUSES | | (B) <u>PASS. MYXEDEMA</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>PNEUMONIA</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> 19 <u>65</u> to <u>2/6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2/5/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Renato N. Espina</u> | | | | 23B. DATE SIGNED <u>2/6/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>RENATO N. ESPINA</u> | | | | 23D. ADDRESS <u>Easton, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/9/1965</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Spring Hill Cemetery</u> | |
| 24D. LOCATION <u>Easton, Md.</u> | | 24E. NAME of REGISTRAR <u>Robert E. Fisher, Md.</u> | | 24F. FUNERAL DIRECTOR <u>Marvin E. Newman, Easton, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | 25B. ADDRESS <u>Easton, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. <u>65 1457</u> | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. <u>65 1457</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Rose Zajdel</u> | | 2. DATE AND HOUR OF DEATH <u>February 5, 1965</u> <u>10:10 p. M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2028 E. Pratt Street</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>2-01</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2028 E. Pratt Street</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>June 15, 1874</u> | 9. AGE (In years last birthday) <u>90</u> | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | |
| 13. FATHER'S NAME <u>Walenty Szczepaniak</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-10-5239</u> | | 17. INFORMANT ADDRESS <u>Frank Zajdel - 2028 E. Pratt St. #21231</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic, Cardio-Vascular Disease</u> | | CAUSE OF DEATH (A) <u>Arteriosclerotic, Cardio-Vascular Disease</u> ?? (B) <u>Generalized Arteriosclerosis</u> ?? (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0 None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 17</u> 19 <u>64</u> to <u>Feb. 5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Joseph F. Drenga, M.D.</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>Feb. 6, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Joseph F. Drenga, M.D.</u> | | | | 23D. ADDRESS M.D. <u>209 S. Chester Str; Baltimore 31, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/9/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>6515 Boston Avenue - Baltimore,</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>George A. Weber - 705 South Ann St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

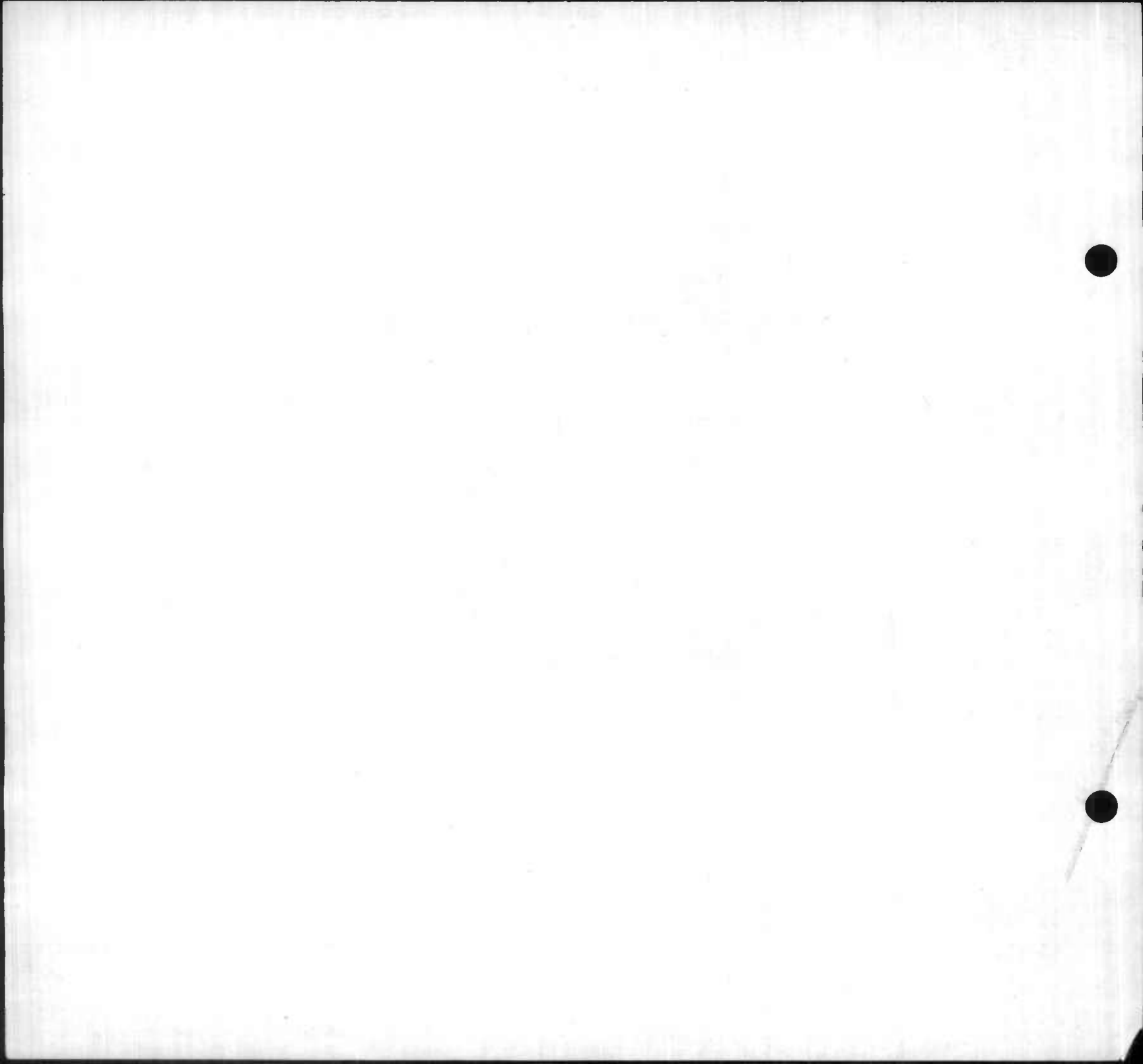
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1458 | |
|--|--|--|---|----------------------|--|
| BIRTH NO. 65 1458 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) <u>Biley D. Warner Sr.</u> | | | 2. DATE AND HOUR OF DEATH <u>2/7/65</u> <u>5:00 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>CERTIFICATE CORRECTED 4-21-65</u> <u>SOUTH BAYTO GEN. HOSP.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ind</u> B. COUNTY <u>23-01</u> | | |
| 5. SEX <u>M.</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | | 8. DATE OF BIRTH <u>7-2-08</u> 9. AGE (In years last birthday) <u>56</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Nebraska</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Co</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | |
| 17. INFORMANT <u>Catherine Warner Above</u> | | | ADDRESS <u>1121 S. HANOVER ST</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Severe Cardiac Arrhythmia</u> <u>Route Myocardial Infarction</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Precipitated by Penicillin Anaphylaxis</u> | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION <u>2</u> | | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | | |
| 21D. TIME OF INJURY (APPROX.) <u>Feb. 6, 1965 A.M.</u> | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/6/1965</u> to <u>2/7/1965</u> , that (I) (we) last saw the deceased alive on <u>2/7/1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | |
| 23A. SIGNATURE <u>Camilo C. Balacuit</u> M.D. | | | 23B. DATE SIGNED <u>2-7-65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Camilo C. Balacuit</u> M.D. | | | 23D. ADDRESS <u>SOUTH BAYTO GEN. HOSP.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>2-11-65</u> | | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u> | | | 24D. LOCATION (City, town, or county) <u>Glen Burnie Ind</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | |
| 25C. FUNERAL DIRECTOR <u>John J. Conaway + Son Inc</u> | | | ADDRESS <u>Baltimore</u> | | |

Letter from South Baltimore General Hosp.
4-21-65 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1459 | |
|---|---------------|--|---------------------------|---|---|
| BIRTH NO. 65 1459 | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH 2-4-65 2.45 P.M. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FREDERICK AUSTIN | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | A. STATE MARYLAND | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY | | D. STREET ADDRESS (If rural, give location) 355 HERRING COURT | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 10-16-96 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper | | 10B. KIND OF BUSINESS OR INDUSTRY machine shop | | 11. BIRTHPLACE (State or foreign country) Md | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILLIAM AUSTIN | | 14. MOTHER'S MAIDEN NAME MARY SCHROEDER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217074761 | | 17. INFORMANT ADDRESS Ruth Dondan | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) SQUAMOUS CELL CARCINOMA METASTATIC, PROBABLY FROM THE LUNG | | 15 mos. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) pneumonia | | 5 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/4 1965 to 2/4 1965, that (I) (we) last saw the deceased alive on 2:45 2/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerry L. Spivak | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/4/65 | |
| 23C. PHYSICIAN'S NAME (Type) JERRY L. SPIVAK | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 2/8/65 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. LOCATION (City, town, or county) Baltimore, Md. | | 24F. LOCATION (City, town, or county) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR John J. Cowan & Son, Inc. | |
| | | | | ADDRESS Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|------------------|---|--|--|---|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1460 | | | | | |
| BIRTH NO. 65 1460 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) JANOWITZ - RAYMOND A. | | | 2. DATE AND HOUR OF DEATH 2-7-65 945 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) A. STATE MD B. COUNTY Balto | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300 | | | | | |
| D. STREET ADDRESS (If rural, give location) 27 Greenwood Ave. | | | | | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 9-21-1914 | 9. AGE (In years last birthday) 50 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MD | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY ARMOCO STEEL | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | |
| 13. FATHER'S NAME JOSEPH A. JANOWITZ | | | | | 14. MOTHER'S MAIDEN NAME ANNA SAKIEVICH | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 212-05-7608 | | 17. INFORMANT MARGARET J. JANOWITZ | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1930 I Brain tumor (metastatic) | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-5-19-65 to 2-7-19-65, that (I) (we) last saw the deceased alive on 2-7-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE S. G. G. G. | | | | | 23B. DATE SIGNED 2/7/65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) SIROOS GERAMI | | | | | 23D. ADDRESS 730 ASHBURTON ST MD. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/10/65 | | 24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | | 24D. LOCATION (City, town, or county) (State) TRUMPS MILL RD MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Janney M.D. | | | 25C. FUNERAL DIRECTOR Cuppel Bros 7110 BELAIR RD | | | | | |

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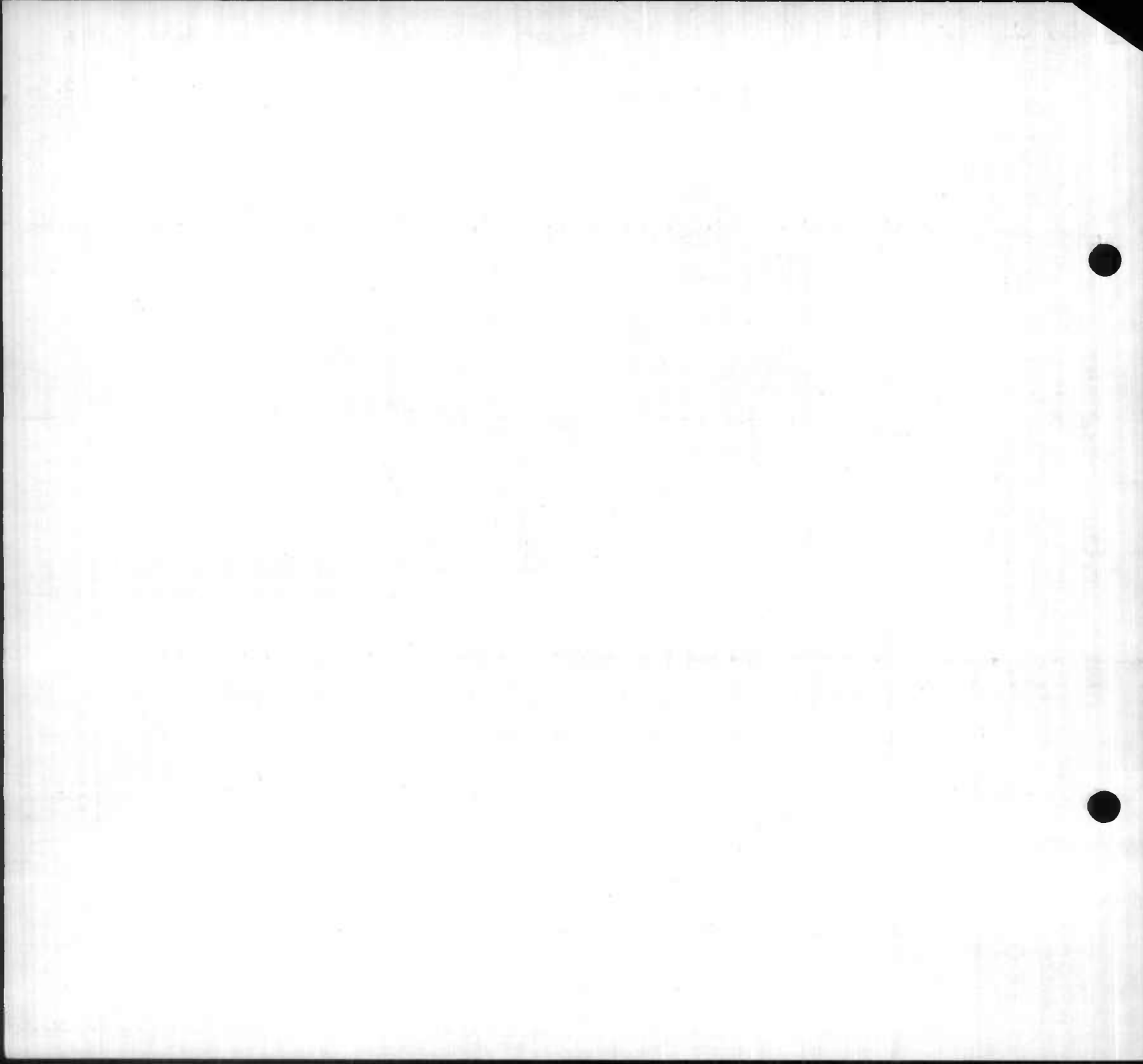
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>65 1461</u> | |
|--|-------------------------|---|---|---|------------------------------|---|-------------------------------|
| BIRTH NO. <u>65 1461</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Janie Jarboe</u> | | 2. DATE AND HOUR OF DEATH <u>February 6, 1965</u> <u>10²⁰</u> <u>A.</u> <u>M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> | | B. COUNTY <u>1904</u> | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | D. STREET ADDRESS (If rural, give location) <u>1702 Ramsey St.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>January 10, 1908</u> | 9. AGE (In years last birthday) <u>58</u> | 10. Under 1 Yr. Months: Days | | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William H. Carneale</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Lillie Hame</u> | | ADDRESS <u>1702 Ramsey St</u> | |
| 18. <u>422.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Cardio-Respiratory Failure</u> DUE TO <u>Uremia</u> (B) <u>Chronic Pyelonephritis</u> DUE TO <u>Arteriosclerotic CVD</u> (C) <u>Ben. atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1964</u> to <u>Feb 6, 1965</u> , that (I) (we) last saw the deceased alive on <u>Feb 6, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>William Appleford</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>Feb 7/65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>William Appleford</u> M.D. | | | | 23D. ADDRESS <u>5501 Park Heights Dr.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/8/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Dorsey Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u> | | | |
| | | | | ADDRESS <u>Pathe Stricker</u> | | | |

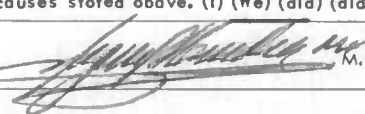


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|-------------------------|--|---|--|---|--|---|--|--|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 1462</u> | | | | | | |
| BIRTH NO. <u>65 1462</u> | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <u>GARRIOTT, GUSSIE, L.</u> | | | 2. DATE AND HOUR OF DEATH <u>2-7-65</u> <u>5:05A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>20-05</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE # 23</u> D. STREET ADDRESS (If rural, give location) <u>2122 EAGLE ST.</u> | | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | | 8. DATE OF BIRTH <u>12-26-13</u> | 9. AGE (In years last birthday) <u>51</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>ILE James O. Zepp.</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah F. Sullivan.</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>ST AGNES HOSPITAL RECORDS</u> <u>WILKENS & CATON AVE, 21229</u> | | | ADDRESS | | | |
| 18. <u>4-20-1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiac Arrest</u> <u>Acute Myocardial Infarction</u> | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> 19 <u>65</u> to <u>2-7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2-7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE  M.D. | | | | | | | 23B. DATE SIGNED <u>2-7-65</u> | | 23C. PHYSICIAN'S NAME (Type) <u>DR. HEREDIA</u> M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>2/11/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>Christian E. Bonnaville</u> 3818 Roland Ave | | | | | |

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65 1463

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1463

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH WYBORSKI

2. DATE AND HOUR PRONOUNCED DEAD

2/4/65 5:55 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1810 Fleet St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
single

8. DATE OF BIRTH

April 24, 1931

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Wyborski

14. MOTHER'S MAIDEN NAME

Rose Bamaskiewicz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-28-5536

17. INFORMANT

ADDRESS

John T. Wyborski, 3416 Harford Road, Baltimore

18. E903.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral confluent broncho-pneumonia
following cranio-cerebral injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

242 S. Broadway

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

1 24 65 7:30 pm

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell in street

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2/5/64

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2-9-65

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

N856 FEB 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook, Inc., 1217 St. Paul Street, 21202

ADDRESS

VALLEY HORGE

THE COMPANY

1
5-530

65 1464

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1464

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MAMIE SMITH

2. DATE AND HOUR PRONOUNCED DEAD

February 6, 1965 9:25 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Brooklyn

D. STREET ADDRESS (If rural, give location)

Bon Aire Avenue

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed

8. DATE OF BIRTH

May 29, 1883

9. AGE (In years last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

(unknown) Emrich

14. MOTHER'S MAIDEN NAME

Mary (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
none

17. INFORMANT

ADDRESS

Charles J. Smith, 1608 Ramblewood Road, 21212

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

ii

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
2-7-65

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

2-9-65

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

FEB 9

1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook, Inc., 1217 St. Paul Street, 21202

ADDRESS

WALLER POLICE

Waller

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

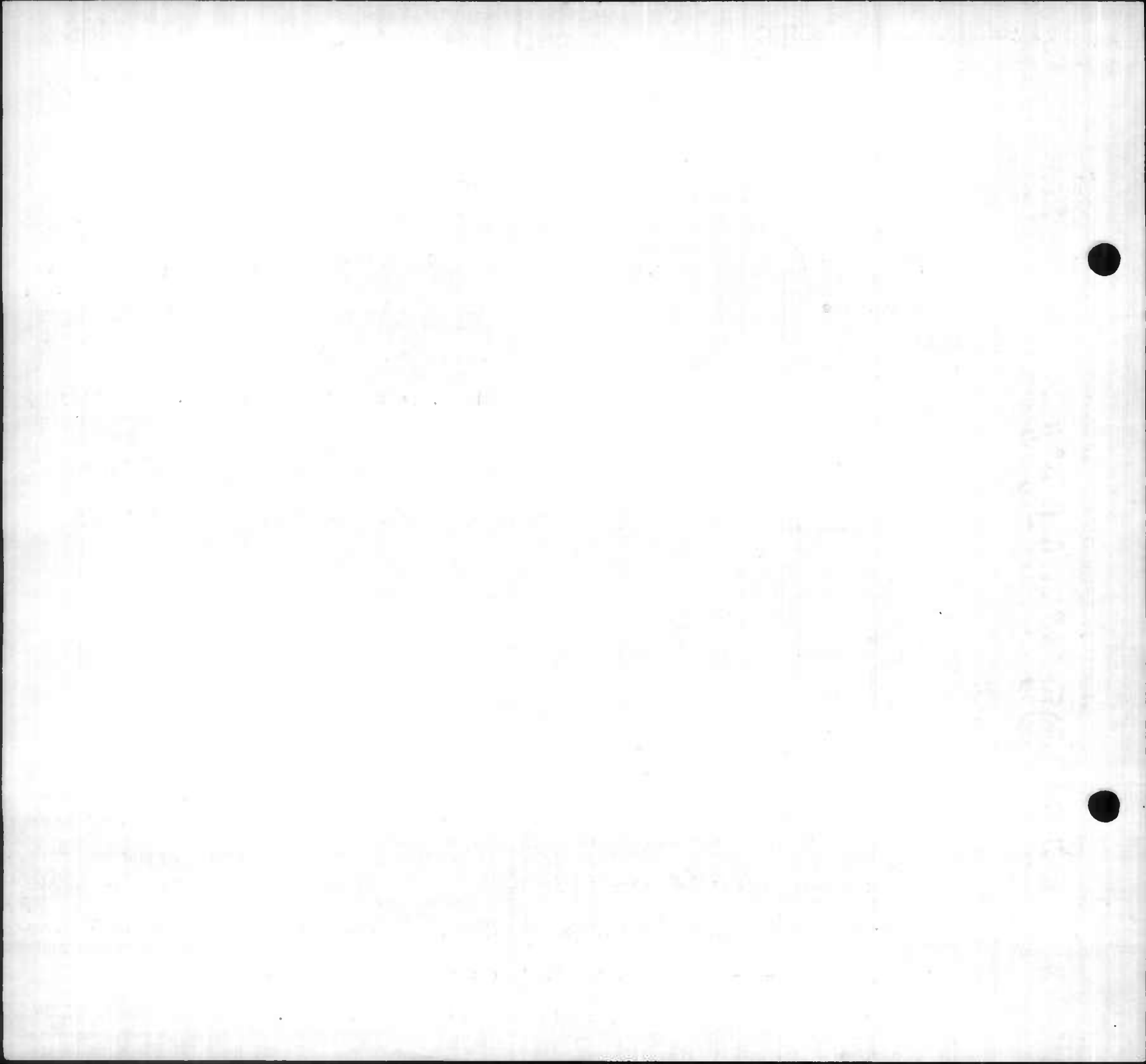
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 1465 | |
|--|---|---|---|---|--|--|-----------------------|
| BIRTH NO. 65 1465 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Warren Conrad Kershaw | | 2. DATE AND HOUR OF DEATH 2-8-65 6:10 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Hospital For the Women of Maryland | | A. STATE Md. | | B. COUNTY 9-06 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 21218 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1736 E. 28th St. | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7-2-13 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | 10B. KIND OF BUSINESS OR INDUSTRY Hut z Ice Bros | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Warren Kershaw | | | | 14. MOTHER'S MAIDEN NAME Peggs, Marie K. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 218-12-7057 | | 17. INFORMANT Mrs. Bessie E. Kershaw | | | |
| | | | | ADDRESS 1736 East 28th Street | | | |
| 18. 420.1 + 260X | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | Expensive, acute Myo-cardial Infarction with acute Pulmonary Edema and Diabetes Mellitus | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6 19 65 to 2-8 19 65 , that (I) (we) last saw the deceased alive on 2-8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Madama Simon M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-8-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-11-65 | | 24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.A. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Towson, Inc., 1217 ST. Paul Street | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 65 1466 | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 65 1466 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Lentz - Mrs. Hilda L.</u> | | | | Feb. 6 - 1965, 7:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours</u> | | | | A. STATE <u>Ocean City Md.</u> B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Ocean City</u> | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>802 Edgewater St.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 28 - 1900</u> | 9. AGE (In years last birthday) <u>64</u> | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>GUSTAV</u> <u>Adolph Moebius</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Fleetwood</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>John L. Lentz, 802 Edgewater St., Ocean City, Md</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.0 I</u> | | CAUSE OF DEATH (A) DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> (B) DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-28-1965</u> to <u>2-6-1965</u> , that (I) (we) last saw the deceased alive on <u>2-6-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Agustin del Campo</u> M.D. | | | | 23B. DATE SIGNED <u>Feb. 6 - 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN DEL CAMPO</u> M.D. | | | | 23D. ADDRESS <u>Bon Secours Hosp. Balto. Md</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-10-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Prospect Hill Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Towson, Maryland 21204</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.A.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Towson, Inc., 1050 York Road, 21204</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 1467 | |
|---|------------------------|--|--------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. 65 1467 | |
| BIRTH NO. 65 1467 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or print) <i>John De Shields (Dashfields)</i> | | 2. DATE AND HOUR OF DEATH <i>2-7-65</i> <i>1P</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>14-03</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Zion Hill Nursing Home</i> <i>1219 W. Fayette St</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>2002 Division St</i> | | | |
| 5. SEX <i>M.</i> | 6. RACE <i>Col.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>12-6-1885</i> | 9. AGE (In years last birthday) <i>79</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Princess Anne, md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Samuel De Shields</i> | | 14. MOTHER'S MAIDEN NAME <i>Sally Winder</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Katie Queen - 2919 Grantley Rd</i> | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cancer of prostate disease unknown</i> | | CAUSE OF DEATH DUE TO (B) DUE TO (C) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov 13</i> <i>1963</i> to <i>Feb 7</i> <i>1965</i> , that (I) (we) last saw the deceased alive on <i>Jan 18</i> <i>1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William D. Watts</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>2-8-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>William D. Watts</i> | | 23D. ADDRESS <i>515 N. Arlington Ave</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-11-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Turnell S. Oden - Balto. Md</i> | |

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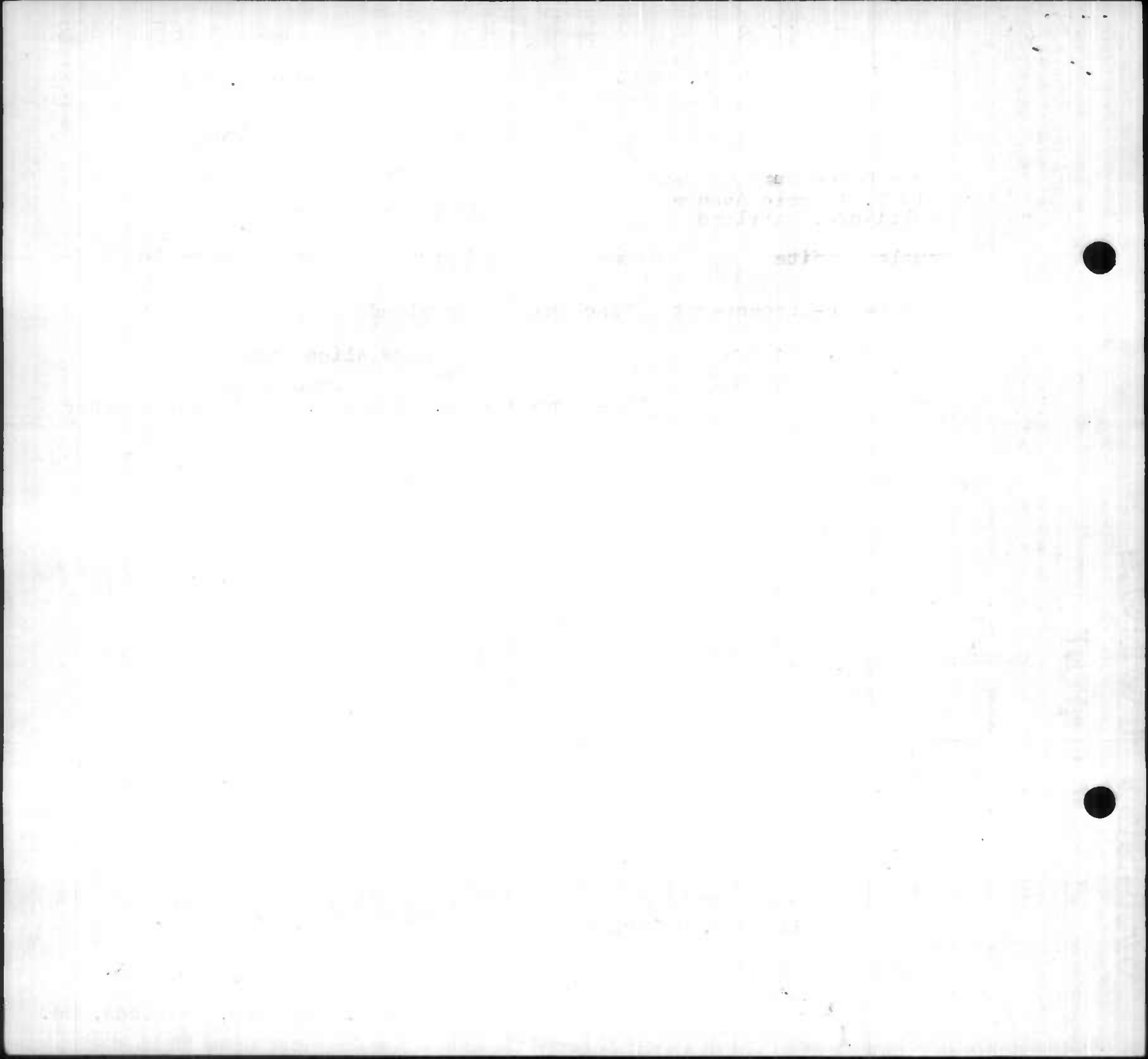
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 1468 | | CERTIFICATE OF DEATH | | Registered No. 65 1468 | |
|--|-------------------------|---|-------------------------------------|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ALICE M. BELL | | | | 2. DATE AND HOUR OF DEATH February 4, 1965 <i>145A M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home 115 E. Melrose Avenue Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3741 Beech Avenue | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/8/1884 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days 5 26 | | If Under 24 Hrs. Hours Min. 13 07 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Teacher-ret Teaching | | | | 10B. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward W. Hepburn | | | | 14. MOTHER'S MAIDEN NAME Mary Alice Jackson | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Yes-Unknown | | 17. INFORMANT samd above | | ADDRESS Mrs. Edmund B. Middleton-daughter | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 + 170X Arteriosclerotic Cardio Vascular Disease | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 1954 | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cancer of the breast | | | | 1954 | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1954 19 Feb 3 to Feb 4 19 65 , that (I) (we) last saw the deceased alive on Feb 3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE William G. Helfrich | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-4-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) William G. Helfrich | | | | 23D. ADDRESS 5006 Roland An-Baths, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/6/65 | | 24C. NAME OF CEMETERY or CREMATORY Rockville Cemetery | | 24D. LOCATION (City, town, or county) (State) Rockville, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md. | | ADDRESS | | | |



M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) 2. DATE AND HOUR PRONOUNCED DEAD

WILLIAM SEMONE

2-8-65 9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

812 W. Lombard Street

UNIVERSITY HOSPITAL - DOA

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6/17/1900

9. AGE (in years last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Meat Cutter

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Semone

14. MOTHER'S MAIDEN NAME

Laura

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Mrs. Grace Semone, 812 W. Lombard St

18. 002.1 + 199.2

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pulmonary tuberculosis and carcinomatosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2-8-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

2/11/65

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION (City, town, or county)

Stonburne

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Witzke, J.H. 4101 Edmondeau

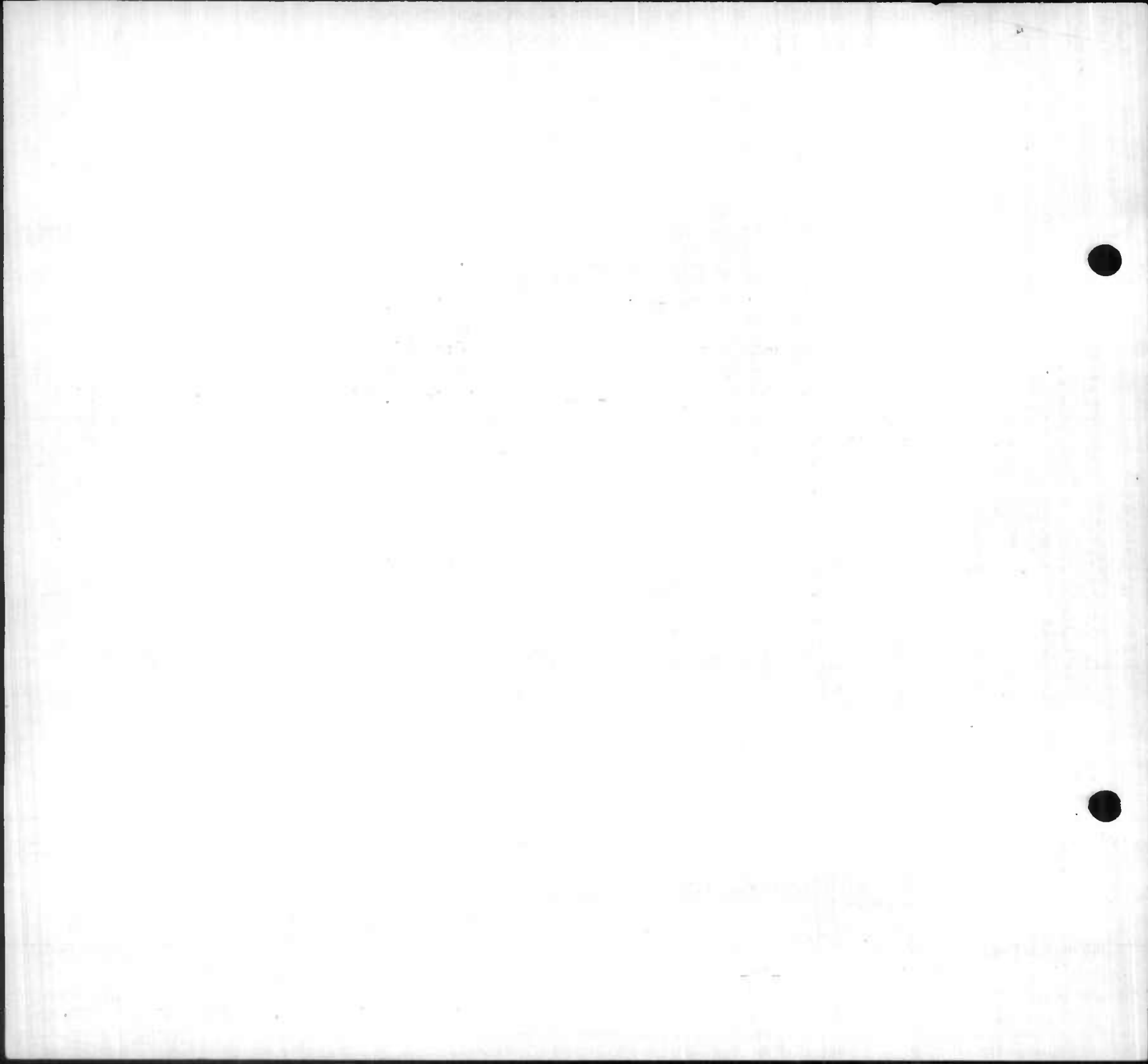
ADDRESS

WALTER B. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

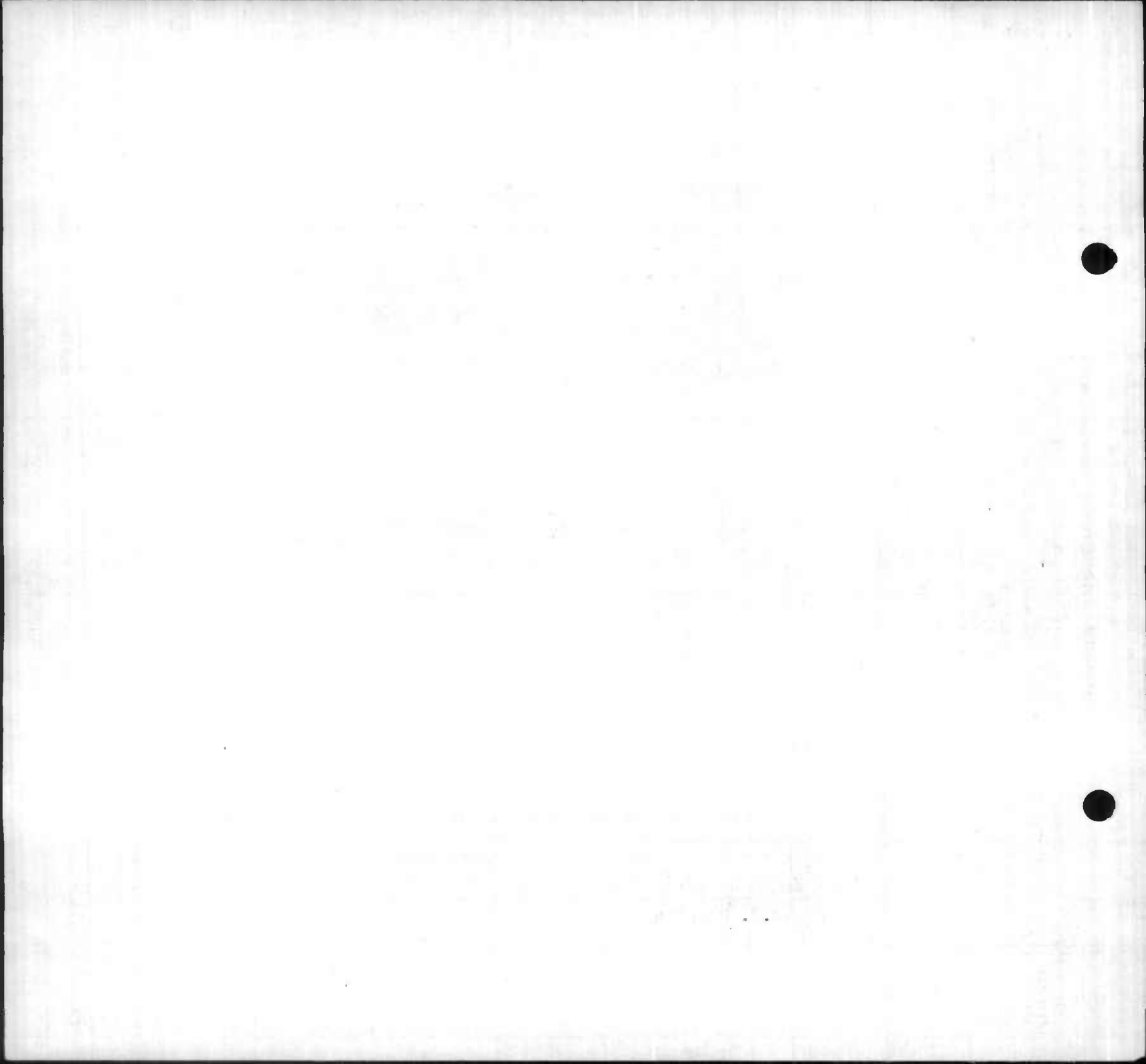
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 1470 | |
|--|--|--|--|---|--|---|--|
| BIRTH NO. 65 1470 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CRAUMER, MINNIE | | 2. DATE AND HOUR OF DEATH 2-5-65 13:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH Home & Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE md B. COUNTY 3-01 | | | |
| 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow | | | | 8. DATE OF BIRTH Dec. 17, 1878 | | 9. AGE (In years last birthday) 86 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME August Puls | | | | 14. MOTHER'S MAIDEN NAME Josephine | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 919-05-7605 | | 17. INFORMANT William A. Vickers ADDRESS 8717 Loch Bend Drive | |
| 18. 545X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED PERITONITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Rupture of The ANTERIOR WALL OF STOMACH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 3 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ephraim Barzaga M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA M.D. | | | | 23D. ADDRESS CHURCH Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-19-1965 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. | | ADDRESS 1901 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

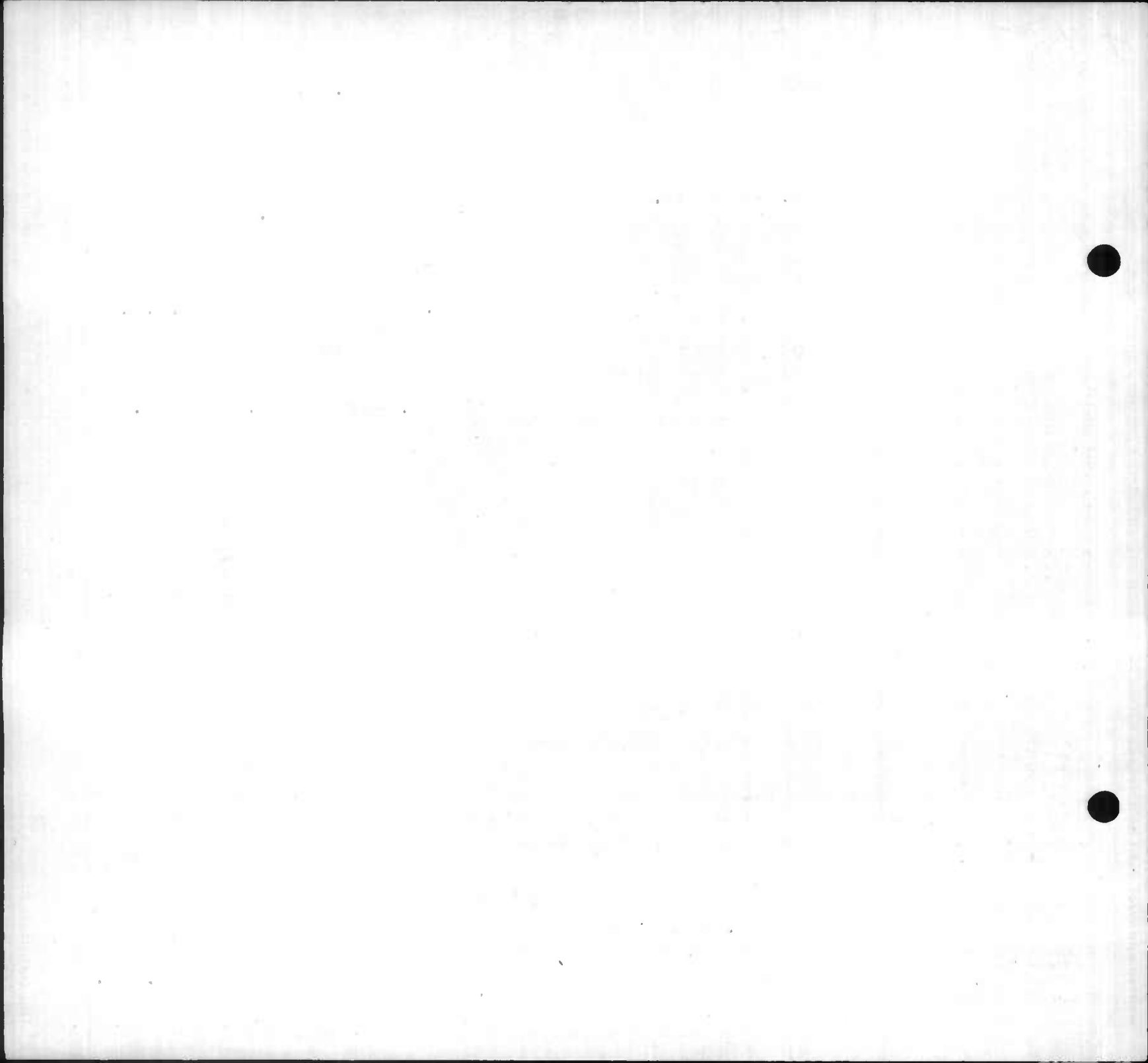
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|---|--------------------------------------|--|--|--|--|--|------------------------------|--|--|
| BIRTH NO. 65 1471 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1471 | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) <u>ALICE Terson</u> | | | | | 2. DATE AND HOUR OF DEATH <u>2-7-65</u> <u>5:30 A</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> | | | | | A. STATE <u>Md.</u> | | | | | B. COUNTY <u>1137 West Franklin Street</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Md.</u> | | | | | 18-02 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>Maryland</u> | | | | | | | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>N</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>9-24-1899</u> | | 9. AGE (In years last birthday) <u>65</u> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 13. FATHER'S NAME <u>George Osborne</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Georgianna</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | | | 17. INFORMANT <u>Robert</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>287x I</u> | | | | | CAUSE OF DEATH (A) <u>Acute Renal Shutdown</u> DUE TO (B) <u>Myocardial Infarction</u> DUE TO (C) <u>G.I. Bleeding</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Approx 5 days</u> <u>30 yrs.</u> <u>14 days</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | | | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? <u>—</u> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-4-65</u> 19 to <u>2-7-65</u> 19, that (I) (we) last saw the deceased alive on <u>2-7-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE <u>J.J. Messina MD</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <u>2-7-65</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>J.J. Messina</u> | | | | | 23D. ADDRESS <u>University Hospital</u> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | 24B. DATE <u>2-11-65</u> | | | | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u> | | | | |
| | | | | | | | | | | 24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | | | | 25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u> | | | | | 25C. FUNERAL DIRECTOR <u>George A. Kilam</u> | | | | |
| | | | | | | | | | | ADDRESS <u>1348 N. Calhoun St.</u> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

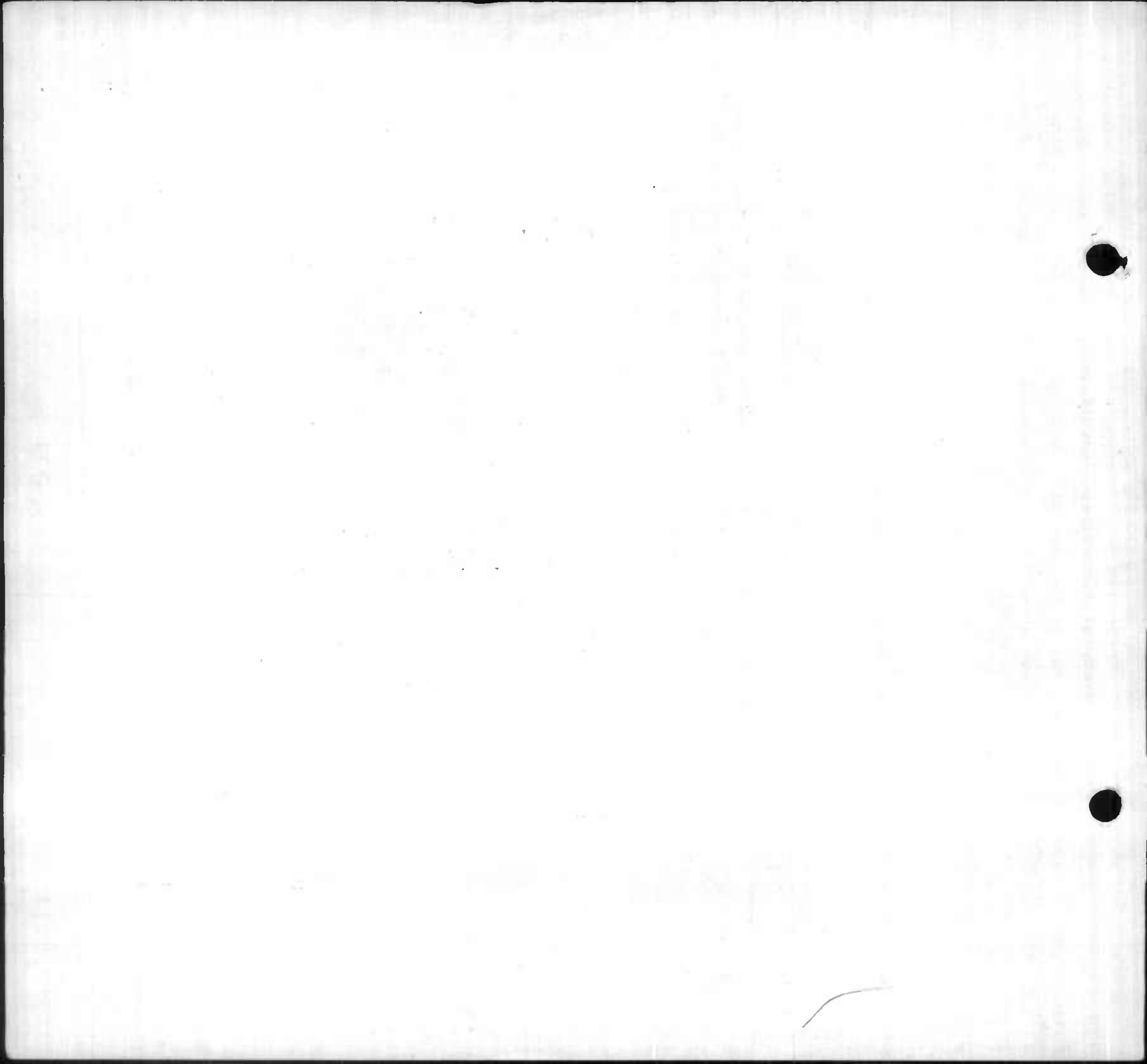
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1472 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 65 1472 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GEORGE HOLMES | | | | 2. DATE AND HOUR OF DEATH Feb. 7, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 513 E. 20 th St. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 513 East 20th St. | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3-12-77 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Jacob Holmes | | |
| 14. MOTHER'S MAIDEN NAME Emma | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Alice H. Bey 513 E. 20th St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary Disease INTERVAL BETWEEN ONSET AND DEATH 2 yr | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1 1963 to Feb 7 1965 , that (I) (we) last saw the deceased alive on Feb 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis A. Johnson M.D. | | | | 23B. DATE SIGNED Feb 8 - 65 | |
| 23C. PHYSICIAN'S NAME (Type) Louis A. Johnson | | | | 23D. ADDRESS 301 E. 20th St. M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/9/65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem. | |
| 24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Parker, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS George H. Kohn 1348 N. Calhoun St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

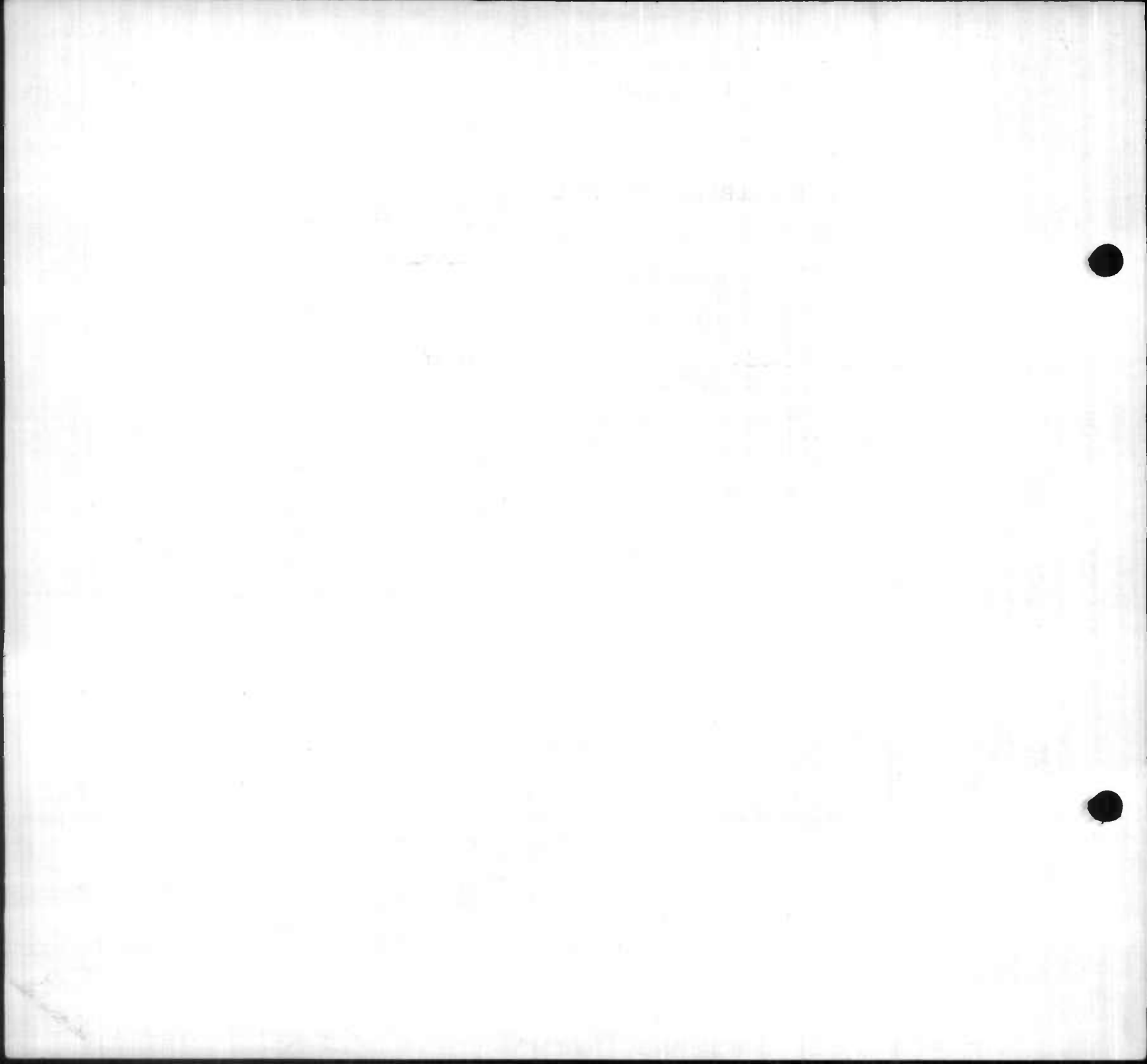
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1473 | |
|---|---------------|---|---------------------------|--|---|
| BIRTH NO. 65 1473 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) James Kennedy | |
| 2. DATE AND HOUR OF DEATH 2-7-65 9:00 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 907 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 1517 Homestead Street | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 12-25-10 | 9. AGE (In years lost birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Kent. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Ed Kennedy | | 14. MOTHER'S MAIDEN NAME Laura Thomas | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. 600.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Uremia (B) Chr. Pyelonephritis w/ (C) Cerebral Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart failure | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-29-65 19 to 2-7-65 19 that (I) (we) last saw the deceased alive on 2-7-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ruperto Manankil M.D. | | | | 23B. DATE SIGNED 2-7-65 | |
| 23C. PHYSICIAN'S NAME (Type) Ruperto Manankil | | | | 23D. ADDRESS M.D. 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-11-1965 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cent | |
| 24D. LOCATION Brooklyn | | 24E. FUNERAL DIRECTOR E. Wilson 1000 Brantley Ave | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1474 | |
|---|--------------------------------|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 1474 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROBERT SPENCER | | | | 2. DATE AND HOUR OF DEATH 11:55 PM 2/6/65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 5-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY D. STREET ADDRESS (If rural, give location) 312 NORTH EDEN STREET | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 3-15-04 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME RICHARD SPENCER | | | 14. MOTHER'S MAIDEN NAME MARY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-03-5151 | | 17. INFORMANT EMMETT Johnson ADDRESS | |
| 18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 433.01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH 2 d | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/6 1965 to 2/6 1965 , that (I) (we) last saw the deceased alive on 2/6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. P. Koko | | | | 23B. DATE SIGNED 2/6/65 | |
| 23C. PHYSICIAN'S NAME (Type) J. P. Koko | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/11/65 | | 24C. NAME OF CEMETERY or CREMATORY McCahey Cent | |
| 24D. LOCATION (City, town, or county) (State) Brooklyn Md | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Choy Wilson 1000 Brantley Ave | | | |



B. 200

65 1475

BALTIMORE CITY HEALTH DEPARTMENT

65 1475

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID BOOZE

2. DATE AND HOUR PRONOUNCED DEAD

2/5/65 2:12 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1516 N. Bradford St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 20,

9. AGE (In years
last birthday)

60

11 Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

David F. Boone

14. MOTHER'S MAIDEN NAME

Francis Boone

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

2/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-9-65

23C. NAME OF CEMETERY or CREMATORY

MT. Calvary Cem.

23D. LOCATION (City, town, or county) (State)

Brooklyn Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

C. O. Wilson 1000 Brantley Ave

ADDRESS

VALLEY FORTGE

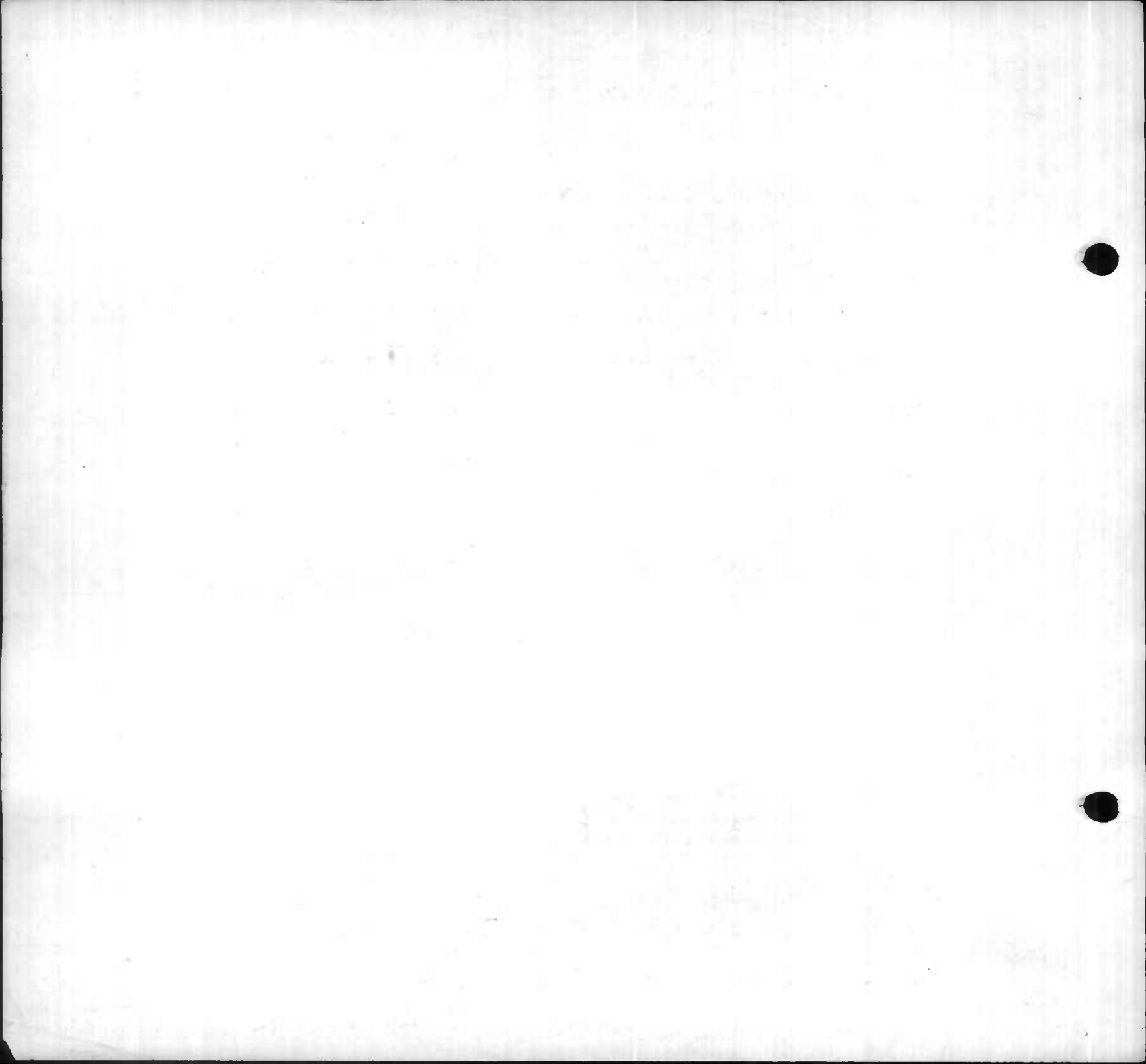
DISCONTINUED

USE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|---------------------|--|---|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1476 | | | | | |
| BIRTH NO. 65 1476 | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Annie Nelson</u> | | | | | 2. DATE AND HOUR OF DEATH <u>Feb. 4, 1965</u> <u>1:10 P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Home - 1208 Mc Cubbin Ct.</u> | | | | | A. STATE <u>Maryland</u> | | | | | |
| | | | | | B. COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>1208 Mc Cubbin Ct.</u> | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>April 1, 1892</u> | 9. AGE (In years last birthday) <u>72</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>John Cephus</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>RITANN</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Bertha Taylor</u> | | | ADDRESS <u>Same</u> | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | | | |
| | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (A) DUE TO <u>Coronary Thrombosis</u> | | | | | |
| | | | | | (B) DUE TO <u>Myocardial Infarction</u> | | | | | |
| | | | | | (C) DUE TO <u>Atherosclerosis of Arteries</u> | | | | | |
| | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> 19 <u>65</u> to <u>2/4</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2/4/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Robert A. Lafuente</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <u>2/6/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. ROBERT A. LAFUENTE</u> | | | | | 23D. ADDRESS <u>822 N. BOND ST BALTO 2205 MD</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-8-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>C. O. Wilson</u> | | | ADDRESS <u>1000 Broadway Ave</u> | |



1
D-120

65 1477 BALTIMORE CITY HEALTH DEPARTMENT 65 1477

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) OSCAR DAVIS

2. DATE AND HOUR PRONOUNCED DEAD February 6, 1965 9:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Squire Hospital

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

7. STREET ADDRESS (If rural, give location) 1097 W. Fayette St.

8. SEX male

9. RACE colored

10. MARITAL STATUS (Specify) Single

11. DATE OF BIRTH Mar 15, 1917

12. AGE (In years last birthday) 47

13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman

14. KIND OF BUSINESS OR INDUSTRY Local 858

15. BIRTHPLACE (State or foreign country) Maffney, S. Carolina

16. CITIZEN OF WHAT COUNTRY? USA

17. FATHER'S NAME UNKNOWN

18. MOTHER'S MAIDEN NAME JOSIE LOVE

19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

20. SOCIAL SECURITY NO. 245-22-7292

21. INFORMANT Lennie Jeffries

22. ADDRESS 2817 W. Mulberry St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTRACRANIAL HEMORRHAGE

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2-7-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 2-11-65

23C. NAME OF CEMETERY or CREMATORY Maffney Cem.

23D. LOCATION (City, town, or county) (State) South Carolina Maffney

24A. DATE REC'D BY HEALTH DEPT. FEB 9 1965

24B. NAME OF REGISTRAR Robert E. Jeffries

24C. FUNERAL DIRECTOR ADDRESS Baltimore Funeral Home Maffney, S. Carolina

VALLEY OF THE GODS

THE GREAT

Robertson

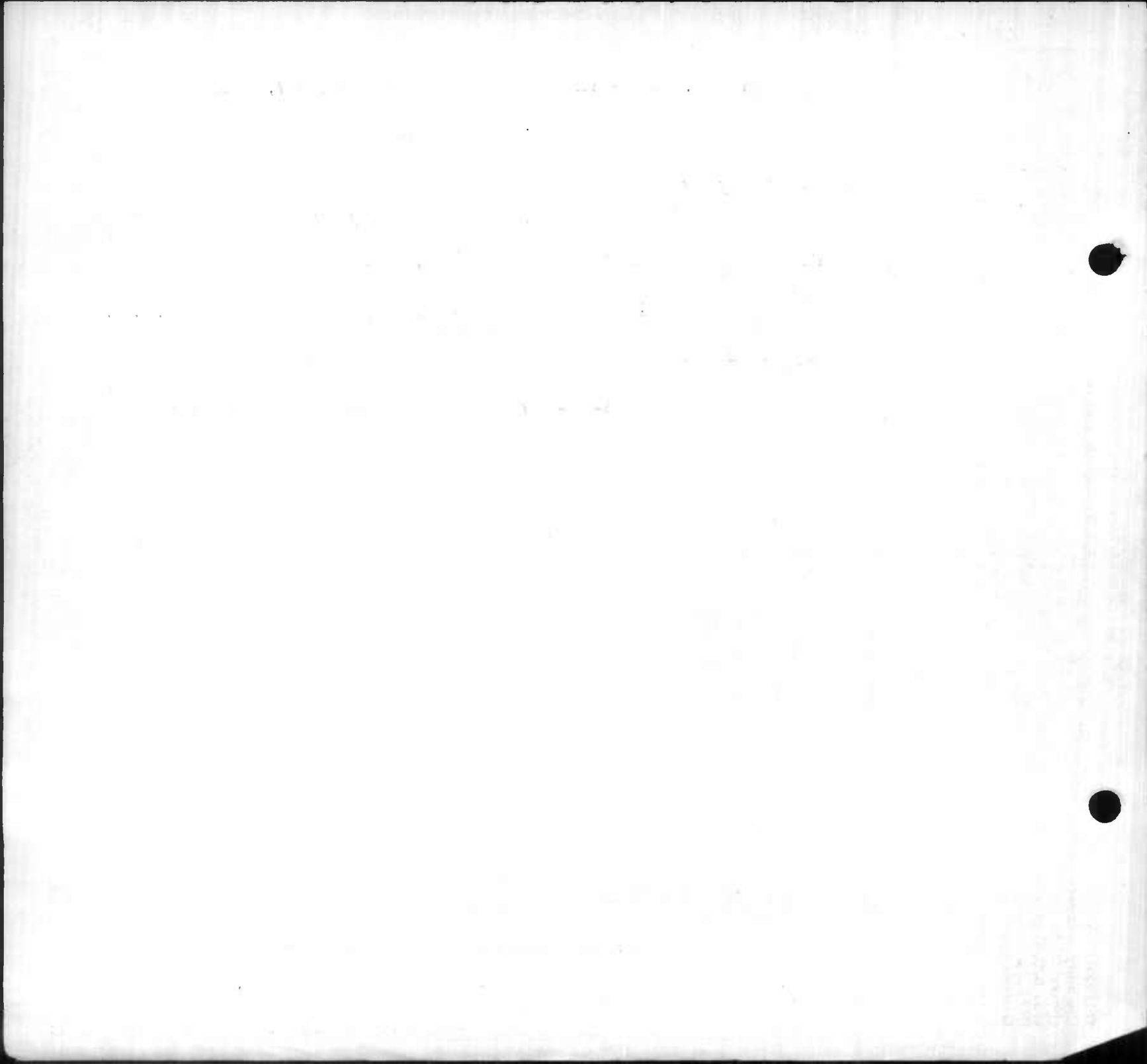
of the

Valley of the Gods

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1478 | |
|---|---|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <div> <p>65 1478</p> <p>BIRTH NO.</p> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div> </div> | | | | | |
| <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center; font-size: 1.1em;">Anna B. Clemmitt</p> | | | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center; font-size: 1.1em;">February 7, 1965</p> | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p style="text-align: center; font-size: 1.1em;">5308 Wesley Avenue</p> <p style="font-size: 0.8em;">FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p style="text-align: center; font-size: 1.1em;">Maryland</p> <p>5. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p style="text-align: center; font-size: 1.1em;">Baltimore</p> <p>6. STREET ADDRESS (If rural, give location)</p> <p style="text-align: center; font-size: 1.1em;">5308 Wesley Avenue</p> | | |
| <p>5. SEX</p> <p style="text-align: center; font-size: 1.1em;">Female</p> | <p>6. RACE</p> <p style="text-align: center; font-size: 1.1em;">White</p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> <p style="text-align: center; font-size: 1.1em;">Married</p> | <p>8. DATE OF BIRTH</p> <p style="text-align: center; font-size: 1.1em;">July 26, 1906</p> | <p>9. AGE (In years last birthday)</p> <p style="text-align: center; font-size: 1.1em;">58</p> | <p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center; font-size: 1.1em;">Clerk</p> | | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="text-align: center; font-size: 1.1em;">Banking</p> | | <p>11. BIRTHPLACE (State or foreign country)</p> <p style="text-align: center; font-size: 1.1em;">Baltimore</p> |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="text-align: center; font-size: 1.1em;">U.S.A.</p> | | | | | |
| <p>13. FATHER'S NAME</p> <p style="text-align: center; font-size: 1.1em;">August Burman</p> | | | <p>14. MOTHER'S MAIDEN NAME</p> <p style="text-align: center; font-size: 1.1em;">Bauman</p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center; font-size: 1.1em;">No</p> | | | <p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center; font-size: 1.1em;">216-05-2578</p> | <p>17. INFORMANT ADDRESS</p> <p style="text-align: center; font-size: 1.1em;">Paul Clemmitt 5308 Wesley Avenue</p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p style="font-size: 0.8em;">(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center; font-size: 1.1em;">I</p> <p style="text-align: center; font-size: 1.1em;">153.8</p> <p style="text-align: center; font-size: 1.1em;">carcinoma of the colon</p> <p style="text-align: center; font-size: 1.1em;">4 mos</p> <p style="text-align: center; font-size: 1.1em;">INTERVAL BETWEEN ONSET AND DEATH</p> | | | | | |
| <p>19. ANTECEDENT CAUSES</p> <p style="font-size: 0.8em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center; font-size: 1.1em;">II</p> <p style="font-size: 0.8em;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| <p>19A. DATE OF OPERATION</p> <p style="text-align: center; font-size: 1.1em;">0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> 19<u>54</u> to <u>2/7</u> 19<u>65</u>, that (I) (we) lost saw the deceased alive on <u>2/5</u> 19<u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE</p> <p style="font-size: 1.2em;"><i>William J. Sumner</i></p> <p style="text-align: right; font-size: 0.8em;">M.D.</p> | | | | <p>23B. DATE SIGNED</p> <p style="text-align: center; font-size: 1.2em;">2/8/65</p> | |
| <p>23C. PHYSICIAN'S NAME (Type)</p> | | | | <p>23D. ADDRESS</p> <p style="text-align: center; font-size: 0.8em;">M.D.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="text-align: center; font-size: 1.1em;">Burial</p> | | <p>24B. DATE</p> <p style="text-align: center; font-size: 1.1em;">2/10/65</p> | | <p>24C. NAME OF CEMETERY or CREMATORY</p> <p style="text-align: center; font-size: 1.1em;">Woodlawn Cemetery</p> | |
| | | <p>24D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center; font-size: 1.1em;">Baltimore, Maryland</p> | | | |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="text-align: center; font-size: 1.2em;">FEB 9 1965</p> | | <p>25B. NAME OF REGISTRAR</p> <p style="text-align: center; font-size: 1.2em;"><i>Robert E. Farley, M.D.</i></p> | | <p>25C. FUNERAL DIRECTOR ADDRESS</p> <p style="text-align: center; font-size: 1.2em;"><i>Ellsworth Armacost</i></p> <p style="text-align: center; font-size: 1.1em;">Ellsworth Armacost 4600 Liberty Heights</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1479 | |
|--|------------------|--|-----------------------------------|---|--|
| BIRTH NO. 65 1479 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Rose W. Drocella | | | | 2 - 6 - 65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MD B. COUNTY 28-41 | |
| 3902 Milford Ave | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | |
| | | | | D. STREET ADDRESS (If rural, give location) 3902 Milford Ave | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid | 8. DATE OF BIRTH 11/2/1873 | 9. AGE (In years last birthday) 91 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILORING | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 012-07-2017 | | 17. INFORMANT ADDRESS Joseph N Miller - 3902 Milford Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | years | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from about 1958 to Feb. 6 1965 , that (I) was last saw the deceased alive on about Feb 5 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE G. Highstein M.D. M.D. | | | | 23B. DATE SIGNED 2-8-65 | |
| 23C. PHYSICIAN'S NAME (Type) G. HIGHSTEIN M.D. M.D. | | | | 23D. ADDRESS 888 W Lombard St BALTO 1 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-9-65 | | 24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Ellsworth Amack 4610 Liberty Light | |

1882

1882

1

65 1480

B-650

BALTIMORE CITY HEALTH DEPARTMENT

65 1480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____ M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **ALFRED BRIM** 2. DATE AND HOUR PRONOUNCED DEAD **2/4/65 11:00 a. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **Lutheran Hospital** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland** B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore 15-41**

D. STREET ADDRESS (If rural, give location) **2930 Clifton St. Ave.**

5. SEX **male** 6. RACE **colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) _____ 8. DATE OF BIRTH **3/25-1917** 9. AGE (In years last birthday) **47** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **DISABLED VETERAN** 11. BIRTHPLACE (State or foreign country) **NEWBORN N.C.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **William O. Brim** 14. MOTHER'S MAIDEN NAME **LIZZIE DAVIS**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **YES WWII** 16. SOCIAL SECURITY NO. _____ 17. INFORMANT **Ray L. Brim 1727 Barclay St.** ADDRESS _____

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Arteriosclerotic cardiovascular disease**

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **no** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. _____ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Wm. U. Spitz** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **2/5/65**

EXAMINER'S NAME (Type) **W. U. Spitz, M.D.** ASSOCIATE MEDICAL EXAMINER ☒

23A. BURIAL CREMATION, REMOVAL (Specify) **Buried** 23B. DATE **2/9/65** 23C. NAME OF CEMETERY or CREMATORY **Baths National** 23D. LOCATION (City, town, or county) (State) **Baltimore**

24A. DATE REC'D BY HEALTH DEPT. **FEB 9 1965** 24B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 24C. FUNERAL DIRECTOR **Marshall P. Hayes** ADDRESS **638 N. B. 11th Ave**

WALL STREET JOURNAL

DATE: 11/11/11

65 1481

BALTIMORE CITY HEALTH DEPARTMENT

65 1481

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM BAKER WILLIAM HENRY BAKER

2. DATE AND HOUR PRONOUNCED DEAD

February 6, 1965 8:15 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5159 Frederick Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 13, 1912

9. AGE (in years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Paper Cutter

10B. KIND OF BUSINESS OR INDUSTRY

Printer Shop

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William T. Baker

14. MOTHER'S MAIDEN NAME

Viola Hartlove

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

War #2

16. SOCIAL
SECURITY NO.

212 10 3763

17. INFORMANT

ADDRESS

21229

Mrs Mae B. Baker 5159 Frederick Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Intracerebral hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

Hypertensive cardiovascular disease

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-7-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/10/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HENRY SANDER & SONS INC.
BALTIMORE MARYLAND 21213

WALLLEY POLICE

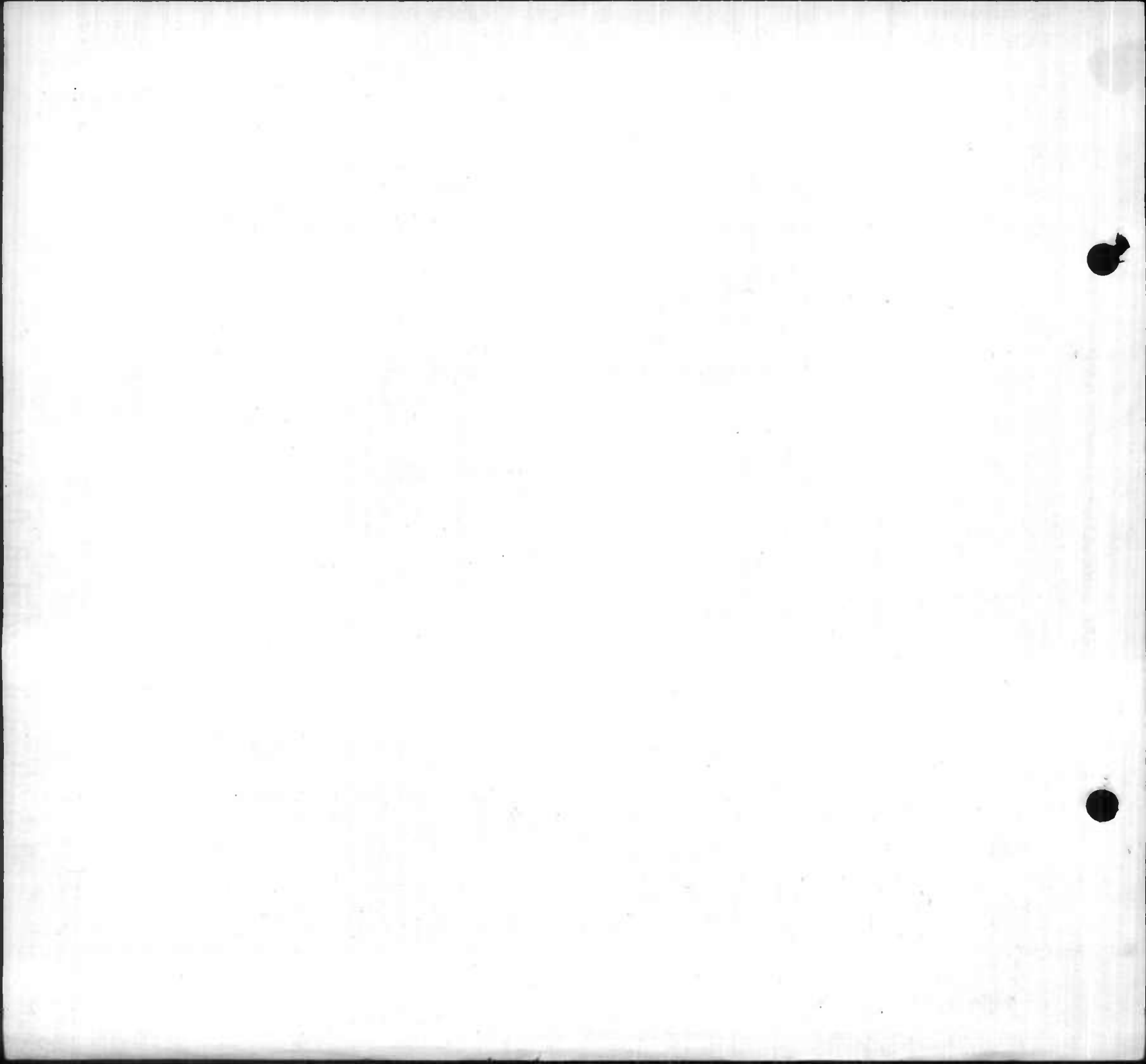
PROSECUTOR

WALLLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|------------------------|--|---|--|--|--|---|--|----------------------------------|--|
| BIRTH NO. 65 1482 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 1482 | | |
| 1. NAME OF DECEASED (Type or Print) <i>Timothy Mackey</i> | | | | | 2. DATE AND HOUR OF DEATH <i>2-4-65 10 A</i> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-04</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>324 E. 21 St.</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | |
| D. STREET ADDRESS (If rural, give location) <i>324 E. 21 St.</i> | | | | | | | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Col.</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>3-28-91</i> | 9. AGE (In years last birthday) <i>73</i> | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retiree</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <i>N.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>James Mackey</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Sallie Mackey</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Hazel Mackey</i> ADDRESS <i>324 E. 21 St.</i> | | | |
| 18. <i>420.1-2604</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Myocardial</i> DUE TO (C) <i>Cholesterol Plaques</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i> | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 22</i> 19 <i>62</i> to <i>2/4</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>2/3/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Hubert E. Forster</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <i>2/6/65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR ALBERT L. LAFOREST</i> | | | | | 23D. ADDRESS <i>822 N. BOND ST BALTIMORE 21205 MD</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>2-8-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St. Calvary Em. A.A. Co</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Md</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1965</i> | | | 25B. NAME OF REGISTRAR <i>Hubert E. Forster, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>Rayner Sanders</i> | | | ADDRESS <i>217 E. Preston</i> | |



1
D-500

65 1483

BALTIMORE CITY HEALTH DEPARTMENT

65 1483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THELMA DUNN

2. DATE AND HOUR PRONOUNCED DEAD

February 7, 1965 8:30 a

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

300 N. Mount St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 N. Mount St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 5, 1937

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wake Co., N. C.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Dunn

14. MOTHER'S MAIDEN NAME

Margaret Cheek

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia, severe
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Fatty metamorphosis of liver
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
2-7-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-13-65

23C. NAME of CEMETERY or CREMATORY

Hillcrest Cemetery

23D. LOCATION (City, town, or county)

(State)

Wake Co., N. C.

24A. DATE REC'D BY HEALTH DEPT.

FEB 9 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

E. E. Lightner - Goldsboro, N. C.

WALLEY BOUGE

Wm. L. L.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|--|--|---|---|--|--|--|
| BIRTH NO. 65 1484 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 1484 | | | | |
| 1. NAME OF DECEASED (Type or Print) IDA MARGARET CARNEY | | | | | 2. DATE AND HOUR OF DEATH 2/7/65 900 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTO, 1 MD | | | | | A. STATE MD B. COUNTY BALTO | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 4305 BELMAR ST Are - | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 4/21/80 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOHN HALLER | | | | | 14. MOTHER'S MAIDEN NAME MARGARET CUBNER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Katherine Arnold - 4305 Belmar Ave. | | | | | |
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) SEPTICEMIA DUE TO SEPTICEMIA (B) HYPERTENSIVE CARDIO-VASC. DISEASE DUE TO DISEASE (C) — | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS (?) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB 1 1965 to FEB 7 1965, that (I) (we) last saw the deceased alive on FEB 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Robert L. G. Ingell | | | | | 23B. DATE SIGNED FEB 7, 1965 | | | 23C. PHYSICIAN'S NAME (Type) Robert L. G. Ingell | |
| | | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-10-65 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore - Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR John G. McIlhenny, Inc. | | | | | |
| | | | | | ADDRESS 6415 Belair Rd. | | | | |

1982

M

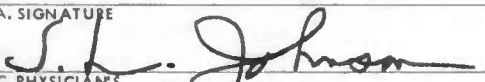
FUNERAL DIRECTOR: IMPORTANT

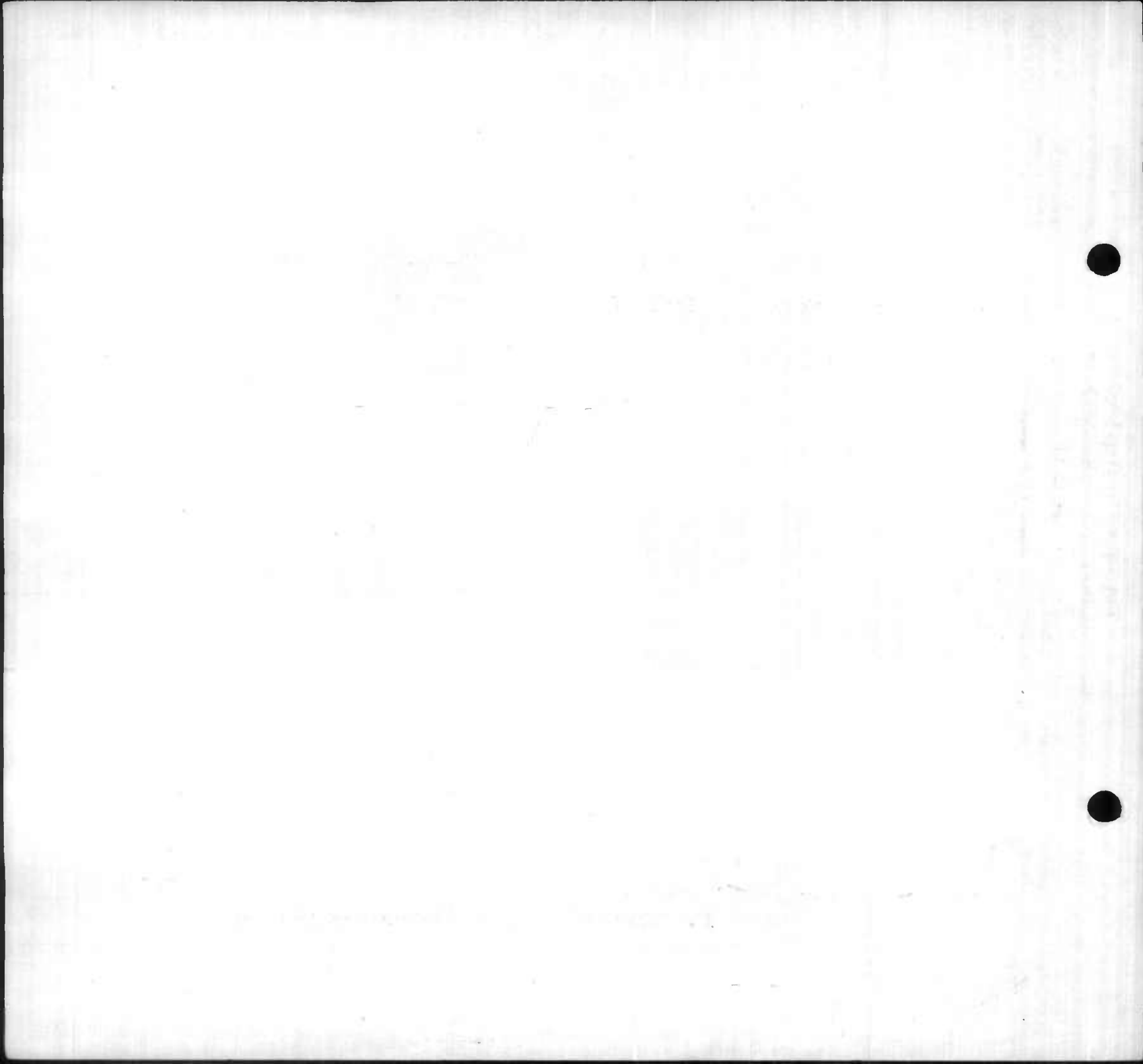
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 1485 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1485 | |
|---|--------------------------|---|--|---|--|---|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BERTHA CHAPMAN | | | | 2. DATE AND HOUR OF DEATH 2-7-65 12:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT Hospital. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 14-01 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 304 LAURENS ST | | | |
| 5. SEX FEMALE | 6. RACE NE GRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH AUG 1, 1907 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY | | 11. BIRTHPLACE (State or foreign country) SPARROWS POINT, MD | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME THOMAS MITCHELL | | | | 14. MOTHER'S MAIDEN NAME BERTHA THORNTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-10-6654 | | 17. INFORMANT MRS. Gherin Johnson - 304 LAURENS ST | | ADDRESS | |
| 18. 138.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) RENAL Insufficiency DUE TO (B) CONGESTIVE HEART FAILURE DUE TO (C) SARCOIDOSIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> At Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-26 19 65 to 2-7 19 65 , that (I) (we) last saw the deceased alive on 2-7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Gilbert L. Bantfield M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-7-65 | |
| 23C. PHYSICIAN'S NAME (Type) Gilbert L. Bantfield M.D. | | | | 23D. ADDRESS 722 N. Fulton Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/10/65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM. | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS HERBERT E. NOTER - 3035 W. NORTH AVE | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

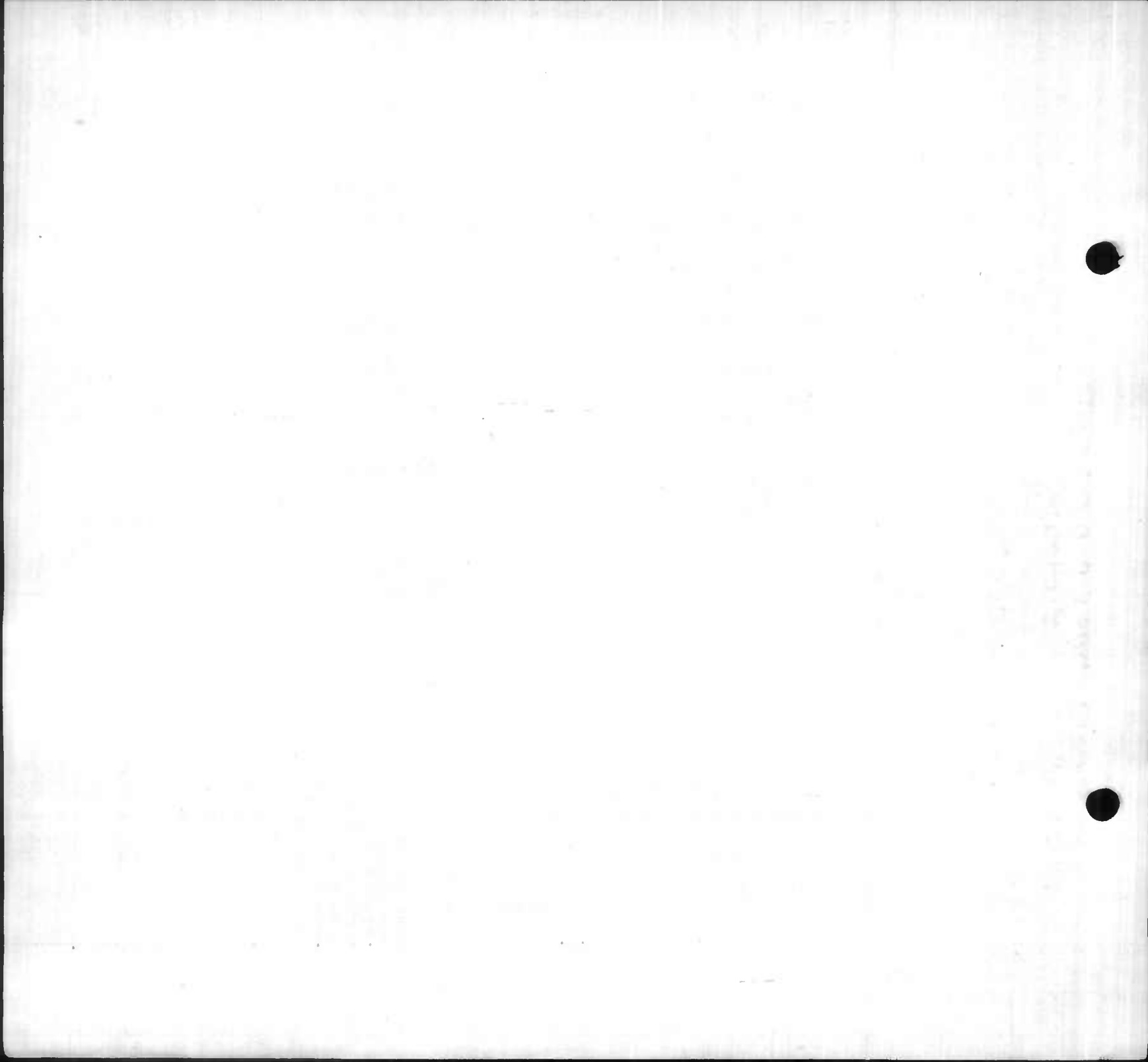
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---|--|---|--|---|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 1486 | | | | | |
| BIRTH NO. 65 1486 | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) JOSEPH WILLIAMS GIBBS | | | | | 2. DATE AND HOUR OF DEATH 2-7-65 12.02 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | A. STATE MARYLAND | | | | | |
| | | | | | B. COUNTY 23-01 | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 944 LEADENHALL STREET | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12-27-99 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker | | | 10B. KIND OF BUSINESS OR INDUSTRY Seafood | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME STEVE WILLIAMS | | | | | 14. MOTHER'S MAIDEN NAME JULIA PRICE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 213-I4-0193 | | 17. INFORMANT Mary Gibbs-944 Leadenhall Street | | | ADDRESS | | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Aspiration Pneumonia DUE TO (B) Bilateral cerebral vascular 2 weeks accidents. DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-3-65 19 to 2-6-65 19, that (I) (we) last saw the deceased alive on 2-7-65 at 12:02 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE  Steve L. Johnson | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 2-7-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Steve L. Johnson | | | | | 23D. ADDRESS Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-12-65 | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn Ct | | | 24D. LOCATION (City, town, or county) (State) Baltimore City | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR Isaiah L. Brown and son | | | ADDRESS 108 W. Montgomery | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

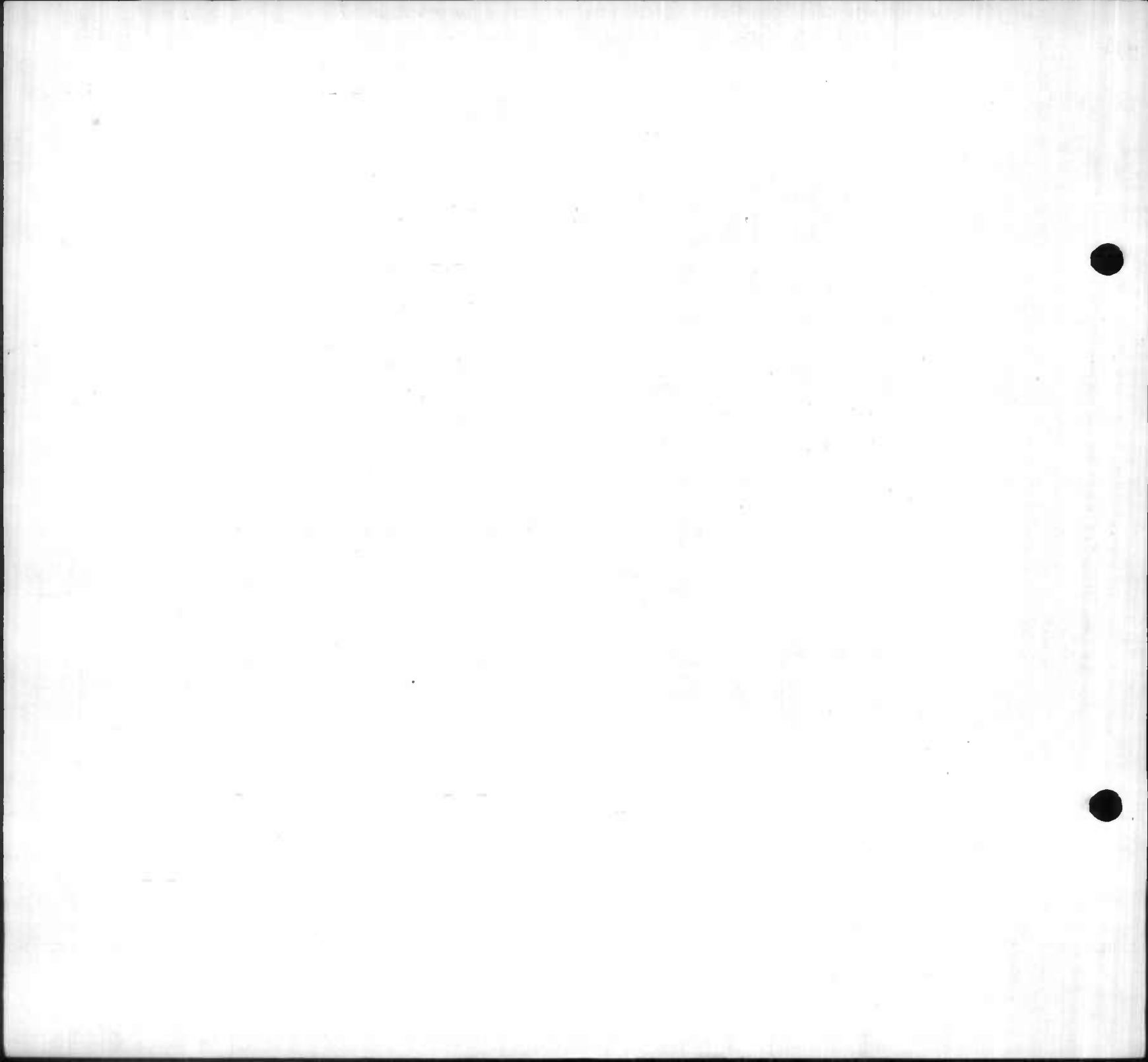
| | | | | | |
|---|------------------|---|---------------------------------|--|--|
| BIRTH NO. 65 1487 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1487 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Dave Brooks, David | | Feb. 4, 1965. 7:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 22-01 | |
| South Baltimore General Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore. # 212.30 | |
| D. STREET ADDRESS (If rural, give location) | | 726 Reynolds Ct. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 22 May 1906 | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| | | | | | Unemployed |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Maryland | | | | | |
| 13. FATHER'S NAME Dave Brooks | | 14. MOTHER'S MAIDEN NAME Fleanor Harmon | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2 | | 16. SOCIAL SECURITY NO. 217-03-8333 | | 17. INFORMANT ADDRESS Dorothy Brooks 146 W. Thimbleburg St | |
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Subarachnoid Hemorrhage (B) DUE TO Rupture of Aorta? Infection (C) Hypertensive Intracerebral Hemorrhage Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 2-1 19 65 to 2-1 19 65, that (we) lost saw the deceased alive on 2-1 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Sigmund A. Amittin, M.D. | | 23B. DATE SIGNED 2-2-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-5-65 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, City. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR J. L. Brown & Son, Montgomery | | 25D. ADDRESS 108 W. Thimbleburg St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 1488 | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 65 1488 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Ollie Price | | 2. DATE AND HOUR OF DEATH 2-1-65 5:00 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217 | | A. STATE Maryland B. COUNTY 16-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1139 N. Stricker Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1-7-1881 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME James Price | | | 14. MOTHER'S MAIDEN NAME Armand Reed | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Ma Price 1139 N Stricker St | |
| 18. 571.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Severe dehydration & Malnutrition DUE TO (B) Enteritis of undetermined etiology DUE TO (C) _____ | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-31-65 19 to 2-1-65 19, that (I) (we) last saw the deceased alive on 2-1-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Hollis Seunarine, M.D. | | | | 23B. DATE SIGNED 2-1-65 | |
| 23C. PHYSICIAN'S NAME (Type) Hollis Seunarine | | | | 23D. ADDRESS 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn & Balt City | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.A. | | 25C. FUNERAL DIRECTOR J. Brown & Son Montgomery St | |



65 1489 BALTIMORE CITY HEALTH DEPARTMENT 65 1489

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) EARL PRICE 2. DATE AND HOUR PRONOUNCED DEAD February 8, 1965 4:44 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-05

D. STREET ADDRESS (If rural, give location) 403 E. Lanvale Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH Nov. 1922 9. AGE (In years last birthday) 42

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) VA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bonnie Price 14. MOTHER'S MAIDEN NAME Elizabeth Merritt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK 16. SOCIAL SECURITY NO. 17. INFORMANT Elizabeth Merritt Phillips ADDRESS South Hill, Va.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic and hypertensive cardiovascular disease

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

ACTUAL SIGNATURE John E. Adams M.D. DATE SIGNED 2-9-65

EXAMINER'S NAME (Type) John E. Adams, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 2-13-65 23C. NAME OF CEMETERY or CREMATORY Westview 23D. LOCATION (City, town, or county) (State) South Hill, Va.

24A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. 24C. FUNERAL DIRECTOR ADDRESS Morton & Dyett Funeral Homes 916 Penna. Avenue Balto., Md. 21201

WALLER POLICE

CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

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CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

CHAS. J. WALLER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 1490 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 1490 | | | | |
| 1. NAME OF DECEASED (Type or Print) Parks, Mary J. | | | | | 2. DATE AND HOUR OF DEATH February 9, 1965 2:25 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 27-06 | | | | | | | | | |
| 5. SEX Female | | | | | 6. RACE White | | | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | | | |
| 8. DATE OF BIRTH 11/26/1911 | | | | | 9. AGE (In years last birthday) 53-84 yrs. | | | | | 10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner (Ret.) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | 13. FATHER'S NAME John W. Parks | | | | | 14. MOTHER'S MAIDEN NAME Annie T. McKew | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk. | | | | | 16. SOCIAL SECURITY NO. 212104132 | | | | | 17. INFORMANT ADDRESS Mr. Maurice B. Parks 2711 Christopher Ave | | | | |
| 18. CAUSE OF DEATH 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Serial pulmonary emboli; coronary arteriosclerosis and myocardial scarring. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) Yes | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | 22. I certify that (I) (this hospital) attended the deceased from January 26, 1965 to February 9, 1965 , that (I) (we) last saw the deceased alive on February 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE W. B. VandeGrift | | | | | 23B. DATE SIGNED February 9, 1965 | | | | | 23C. PHYSICIAN'S NAME (Type) William B. VandeGrift | | | | |
| 23D. ADDRESS 1400 N. Caroline St., Baltimore, Md. 21213 | | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 2/12/1965 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. | | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairley | | | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. | | | | | 25D. ADDRESS 5305 Harford Rd. | | | | |

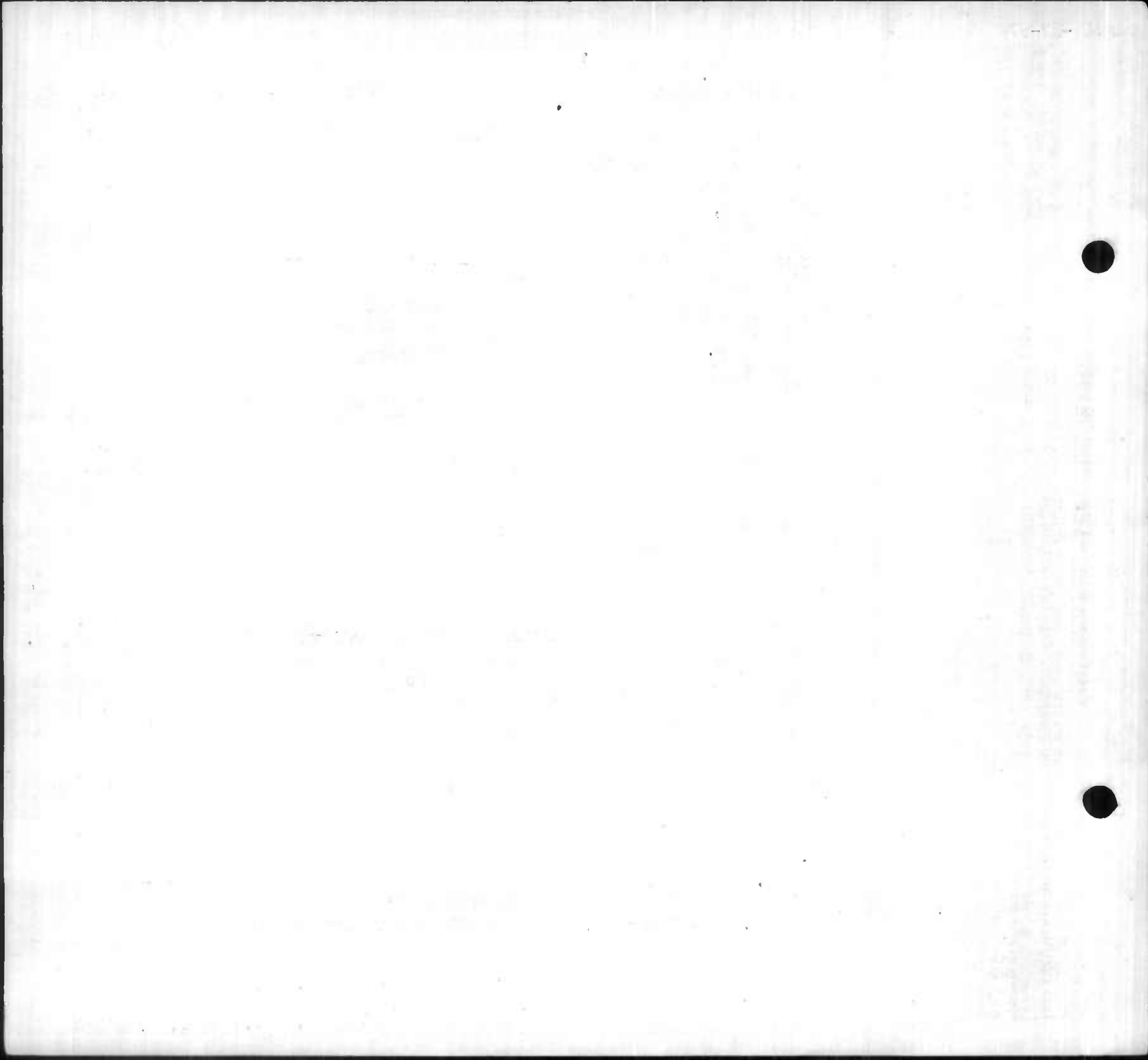
Birth Cert. A-39811 - 1880 # Record Room
of St. Joseph's Hospital 2-17-65 M.H.

cdg:41-37-97

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 1491</u> | |
|---|---------|--|------------------|--|--|
| BIRTH NO. <u>65 1491</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | February 8, 1965 1:30 P.M. | | | |
| Pauline Meyers | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | B. COUNTY 27-05 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 7133 Harford Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Female | White | Widowed | 3-17-74 | 90 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| MENTIS | | WILHELMINA | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. <u>493 X I</u> | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Pneumonia | | | 3 days |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | Arteriosclerotic Cardiovascular Disease | | | Many yrs. |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 24, 1964 to February 8, 1965, that (I) (we) last saw the deceased alive on February 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 2-8-65 | |
| Robert Cooke | | 4940 Eastern Avenue 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 2/11/65 | | HOLY REDEEMER CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| BALTO., MD. | | Robert E. Jarboe M.D. | | LEONARD J. RUCK, INC., BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 9 1965 | | Robert E. Jarboe M.D. | | LEONARD J. RUCK, INC., BALTO., MD. | |
| 25D. ADDRESS | | 25E. NAME OF REGISTRAR | | 25F. FUNERAL DIRECTOR | |
| 21214 | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

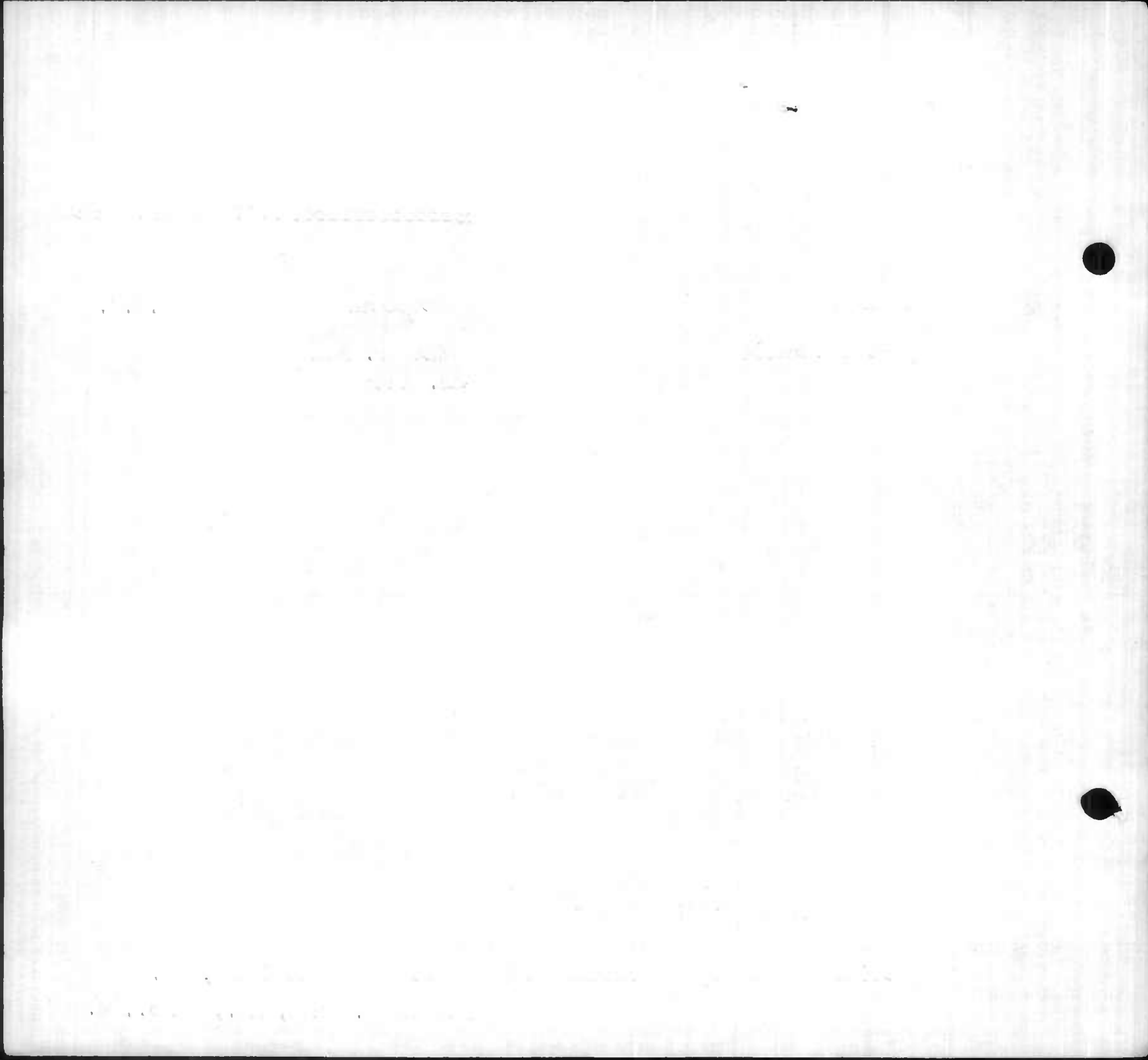
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1492 | |
|--|---|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 1492 CERTIFICATE OF DEATH </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) RUTH HINKLEMAN </div> <div> 2. DATE AND HOUR OF DEATH 2/8/ '65 5:05 </div> <div> P. M. </div> </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOPKINS </div> <div> (If not in hospital or institution, give street address or location) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1351 PENTWOOD ROAD | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11/26/11 | 9. AGE (In years last birthday) 53 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME HARRY VENTON Vinson | | | 14. MOTHER'S MAIDEN NAME ELIZABETH Legg | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-03-2199 | 17. INFORMANT Mr. John F. Hinkleman Sr. | | ADDRESS Same |
| 18. 744.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) SHOCK DUE TO (B) RESPIRATORY FAILURE DUE TO (C) MYASTHENIA GRAVIS INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2 3/29 1964 to 5:05 PM 2/8 1965, that (I) (we) last saw the deceased alive on 2/8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael Lesch | | | | 23B. DATE SIGNED 2/8 | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL LESCH | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/11/65 | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Tarkenton | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd. | |

| Date | Time | Location | Altitude | Remarks |
|------|-------|----------|----------|---------|
| 1952 | 10/10 | 1000 | 1000 | 1000 |
| 1952 | 10/11 | 1000 | 1000 | 1000 |
| 1952 | 10/12 | 1000 | 1000 | 1000 |
| 1952 | 10/13 | 1000 | 1000 | 1000 |
| 1952 | 10/14 | 1000 | 1000 | 1000 |
| 1952 | 10/15 | 1000 | 1000 | 1000 |
| 1952 | 10/16 | 1000 | 1000 | 1000 |
| 1952 | 10/17 | 1000 | 1000 | 1000 |
| 1952 | 10/18 | 1000 | 1000 | 1000 |
| 1952 | 10/19 | 1000 | 1000 | 1000 |
| 1952 | 10/20 | 1000 | 1000 | 1000 |
| 1952 | 10/21 | 1000 | 1000 | 1000 |
| 1952 | 10/22 | 1000 | 1000 | 1000 |
| 1952 | 10/23 | 1000 | 1000 | 1000 |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

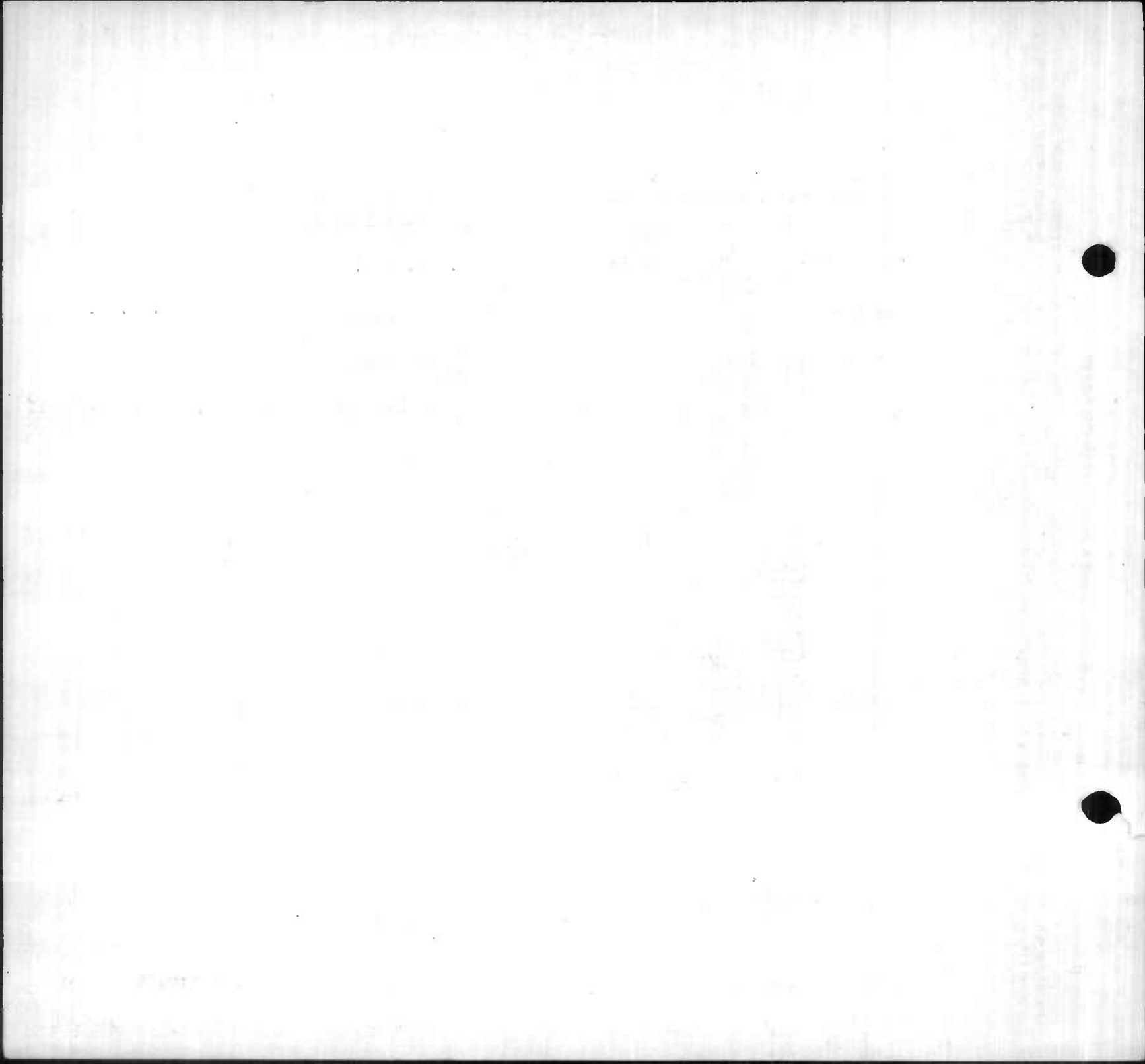
| BIRTH NO. 65 1493 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 1493 | |
|---|---------------------|--|------------------------------------|---|--|--|---|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Browning, William</u> | | | | 2. DATE AND HOUR OF DEATH <u>2/7/65</u> <u>1:25</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>X</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) xxxxxx <u>1121 McAleer Court</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>3/27/11</u> | 9. AGE (In years last birthday) <u>53</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Edward Browning</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary V. Selby</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. DECEASED <u>HOSPITAL RECORD</u> | | ADDRESS |
| 18. <u>416X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>EMBOLUS TO CORONARY ARTERY</u> DUE TO (B) <u>SUBACUTE BACTERIAL ENDOCARDITIS</u> DUE TO (C) <u>RHEUMATIC HEART DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NAD (R) NEPHRECTOMY YRS AGO - ASPIRATION PNEUMONIA SEVERAL DAYS AGO</u> | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> 19 <u>65</u> to <u>2/7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>L. Bradley Baker</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2/7/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>LYNN BRADLEY BAKER</u> | | | | 23D. ADDRESS M.D. <u>UNIVERSITY HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/11/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., Balto. Md.</u> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

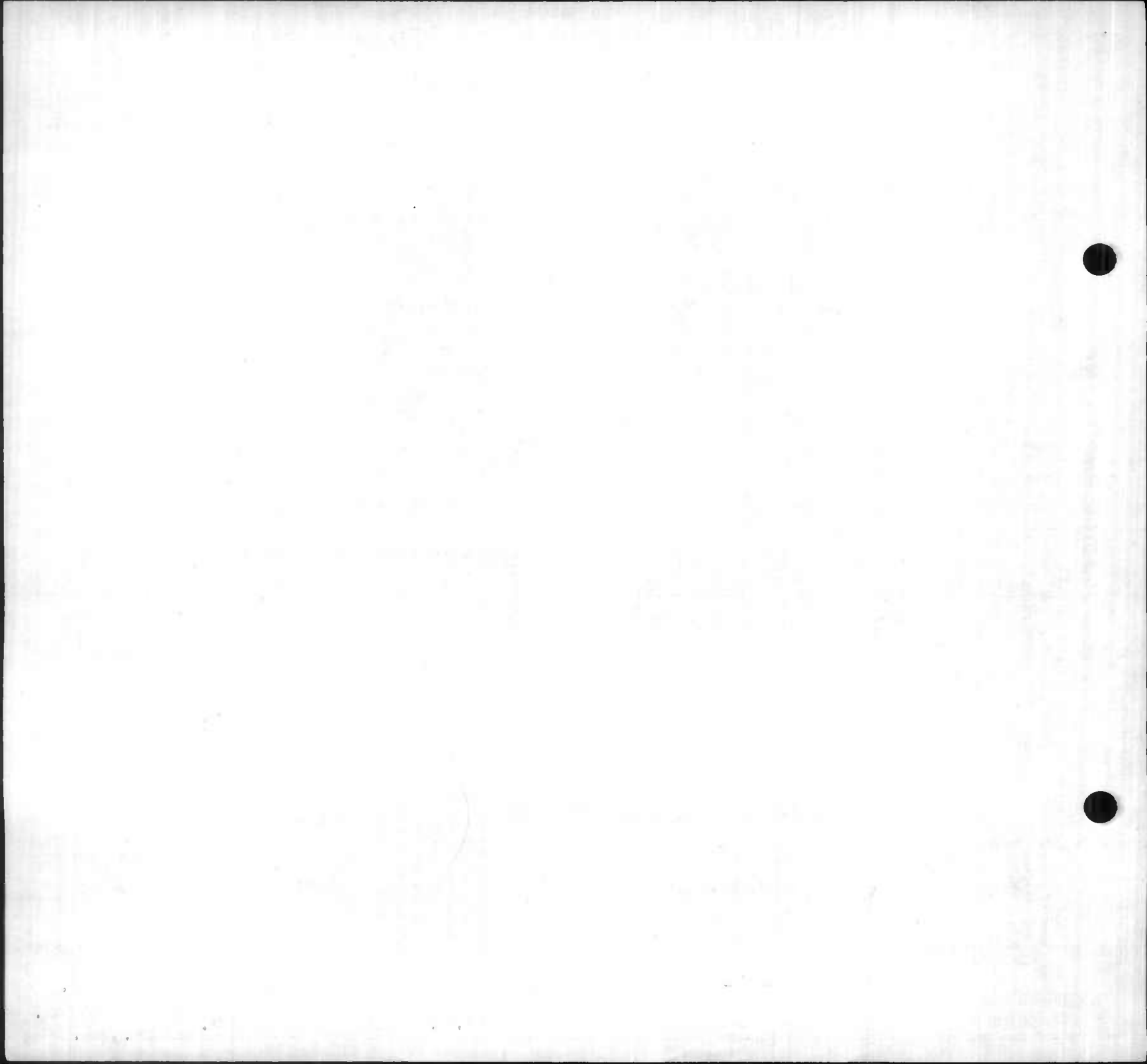
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1494 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 65 1494 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Maude Huff | | 2. DATE AND HOUR OF DEATH February 8, 1965 <i>5 PM</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-48 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 828 East Lake Avenue Baltimore, Maryland 21212 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 828 East Lake Avenue 21212 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Aug. 31, 1882 | 9. AGE (In years last birthday) 82 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Charles Kidd | | 14. MOTHER'S MAIDEN NAME Ann Howard | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Miss Marian Huff ADDRESS 828 East Lake Avenue Baltimore, Maryland 21212 | |
| 18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Uremia (A) DUE TO C.V.A. of 3 yrs duration (B) DUE TO Cerebral arteriosclerosis (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Semility | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 14 62 19 to Feb 4 63 1963, that (I) (we) last saw the deceased alive on Feb 4 63 1963 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>M. Paul Byerly</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/5/65 | |
| 23C. PHYSICIAN'S NAME (Type) M. Paul Byerly | | 23D. ADDRESS 5820 York Rd Baltimore, Md. 21212 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/11/1965 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery | |
| 24D. LOCATION Baltimore, County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | |
| | | 25C. FUNERAL DIRECTOR Wm. J. Tietner & Sons | | ADDRESS Baltimore, Md. 17 North & Pennsylvania | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

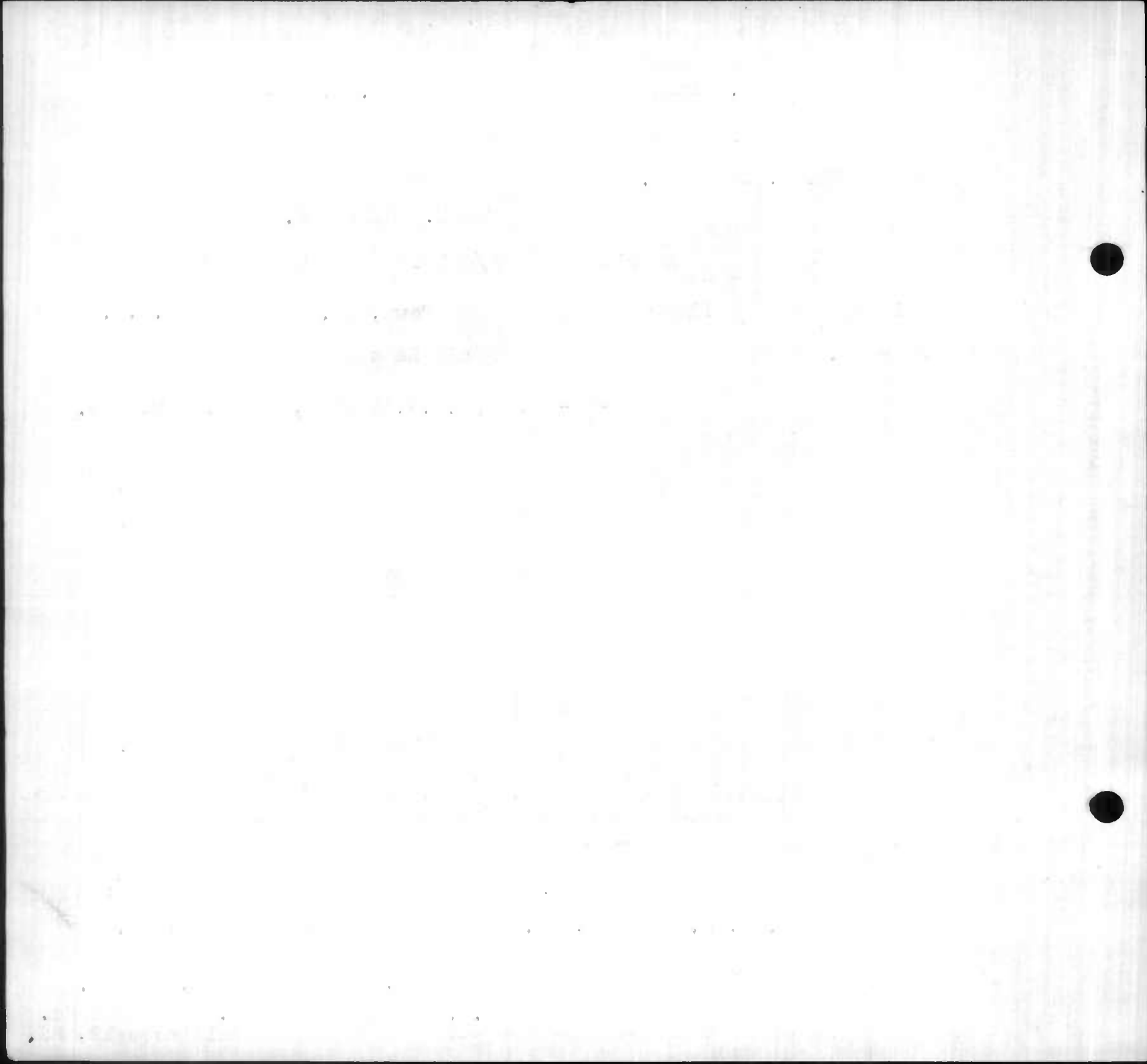
| | | | | | |
|--|------------------------|--|------------------------------------|---|--|
| BIRTH NO. 65 1495 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 1495 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) DR. CHARLES L. WARNER | | | | 2-9-65 1:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY 27-09 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 4210 Lock Raven Blvd. | |
| 5. SEX Male | 6. RACE Cau. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/11/89 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY Medical | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME George T. Warner | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I | | | | 16. SOCIAL SECURITY NO. 219-30-0759 | |
| 17. INFORMANT Sarah W. Warner | | | | ADDRESS Above | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH HEMOPERICARDIUM & CARDIAC TAMPONADE MYOCARDIAL INFARCT & RUPTURE ARTEROSCLEROTIC HEART DISEASE | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6 19 65 to 2-9 19 65 , that (I) (we) last saw the deceased alive on 2- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Helen M. Fabian | | | | 23B. DATE SIGNED 2-9-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. LESTER WALL | | | | 23D. ADDRESS Maryland Gen. Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-11-65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. STATE Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | |
| 25D. ADDRESS 4905 York Rd. Balto., Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 1496 | |
|---|---|--|--|---|---|
| BIRTH NO. 65 1496 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Raymond W. Dixon | | | 2. DATE AND HOUR OF DEATH Feb. 8, 1965 1 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 726 E. Lake Ave. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 726 E. Lake Ave. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/6/1885 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller | | 10B. KIND OF BUSINESS OR INDUSTRY Flour & Feed | 11. BIRTHPLACE (State or foreign country) Horn Town, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James C. Dixon | | | 14. MOTHER'S MAIDEN NAME Annie Kate | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 216-10-3719 | 17. INFORMANT ADDRESS Mrs. O.E. Fleming, 726 E. Lake Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| | | | (A) Acute Coronary Occlusion DUE TO | | 4 MONTHS |
| | | | (B) ARTERIO SCLEROTIC C.V.D. DUE TO | | YEARS |
| | | | (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CARCINOMA OF BLADDER | | 18 MOS |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN 25 19 65 to FEB 8 19 65 , that (I) (we) last saw the deceased alive on FEB 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. J. Venable, Jr. M.D. | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-8-65 |
| 23C. PHYSICIAN'S NAME (Type) Dr. S. J. Venable, Jr. | | | 23D. ADDRESS 7215 York Road, Baltimore, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/11/1965 | 24C. NAME OF CEMETERY or CREMATORY Bethany Methodist Cem. | | 24D. LOCATION (City, town, or county) (State) Pocomoke City, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 9 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | |



B-620

65 1497

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 1497

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|---|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) JOHN BURKE | | | | 2. DATE AND HOUR PRONOUNCED DEAD 2-7-65 4:26 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL-DOA | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1400 S. Hanover Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH Jan. 1, 1900 | 9. AGE (In years last birthday) 65 yrs. | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Dept. | | 10B. KIND OF BUSINESS OR INDUSTRY City of Balto. | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Burke | | | | 14. MOTHER'S MAIDEN NAME Delia Hughes | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 224-14-0377 | | 17. INFORMANT ADDRESS Margaret Maka 3815 Brooklyn Ave. | | | |
| 18. CAUSE OF DEATH 002.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral pulmonary tuberculosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE PETER W. RIECKERT, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-8-65 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2/10/65 | | 23C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery Old Frederick Rd. Balto. Md | | 23D. LOCATION (City, town, or county) (State) | |
| 24A. DATE REC'D BY HEALTH DEPT. FEB 10 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS KRAUSE FUNERAL HOME 1216 S. Charles St. Balto. 30 Md. | | | |

WALTER H. GIBBS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|--|--|
| BIRTH NO. 65 1498 M.E. CASE NO. | | CERTIFICATE OF DEATH Registered No. 65 1498 | |
| 1. NAME OF DECEASED (Type or Print) KRUL MRS. EVA L. | | 2. DATE AND HOUR OF DEATH 6 P.M. on 2-8-1965 6 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital Baltimore 31. Md, | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #24 D. STREET ADDRESS (If rural, give location) 612 S. Curley St. | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 24, 1900 64 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Connecticut | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Krass | | 14. MOTHER'S MAIDEN NAME Louise Zavanek | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mr. Frank F. Krul, 612 S. Curley St. | | ADDRESS 612 S. Curley St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction - 12 hours Ventricular tachycardia - few minutes and fibrillation | | INTERVAL BETWEEN ONSET AND DEATH few minutes | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. TH | |
| 19A. DATE OF OPERATION - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (H) (this hospital) attended the deceased from 4:30 P.M. on 2-8-1965 to 6 P.M. on 2-8-1965 , that (H) (we) last saw the deceased alive on 2-8-1965 at 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Kishor C. Mehta | | 23B. DATE SIGNED 2-8-1965 | |
| 23C. PHYSICIAN'S NAME (Type) KISHOR C MEHTA | | 23D. ADDRESS Church Home and Hospital, Balt-31 Md | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/11/65 | |
| 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus | | 24D. LOCATION (City, town or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 10 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE | | ADDRESS 1808 EASTERN AVE | |

VISHOR C MENTA

KISOR C MENTA

3-8-1952

Harmon 2-4-52, City of...

CHURCHMAN AND HORTON

✓

3-8-1952

Acute myocardial infarction - 1st time
Ventricular tachycardia
and fibrillation

John Kiser

Hanscombe

Mary...

James H. Hoot...

Comet...

Lease...

...

...

...

...

1
M. 655

BALTIMORE CITY HEALTH DEPARTMENT

65 1499

BIRTH NO.

65 1499

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CARLTON MOORMAN

2. DATE AND HOUR PRONOUNCED DEAD

February 3, 1965 10:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

700 Fleet St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

8 S. Broadway

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

JUNE 1902

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PAPERHANGER

10B. KIND OF BUSINESS OR INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

VA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles W.

14. MOTHER'S MAIDEN NAME

Sally Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

214-12-1707

17. INFORMANT

Moorman ADDRESS

Charles W. Moorman 3224 EVERGREEN

18.

4-22-1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK

NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-3-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

FEB 5, 1965

23C. NAME OF CEMETERY or CREMATORY

MT CARMEL

23D. LOCATION

(City, town, or county)

(State)

German Hill Baltimore

24A. DATE REC'D BY HEALTH DEPT.

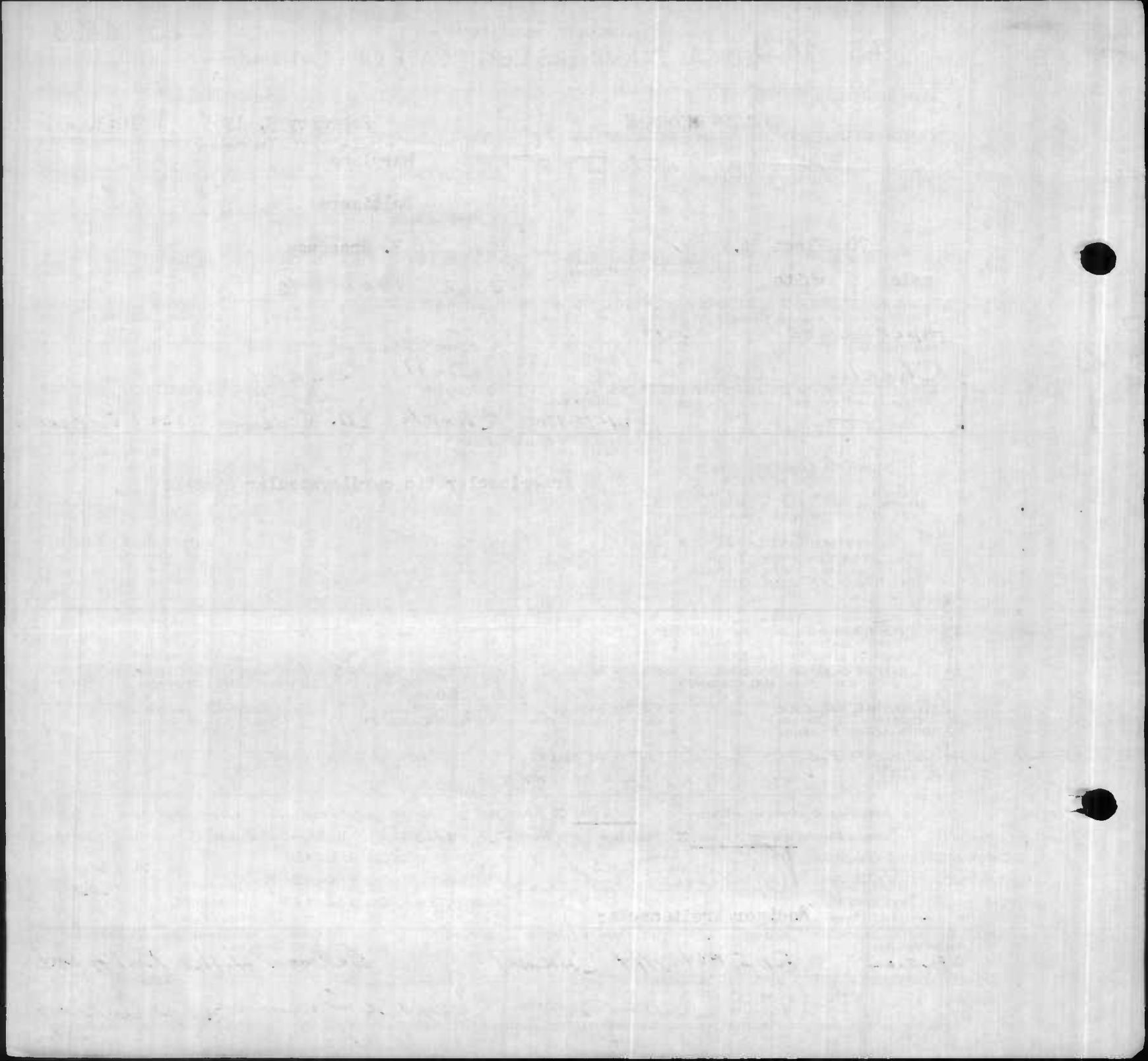
FEB 10 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Joseph K. Zannino 363 S. Conkling



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 1500 | |
|--|------------------|--|--|--|--|---|--|--|--|--|--|
| BIRTH NO. 65 1500 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) DANIEL L. FIRESTONE, JR. | | | | 2. DATE AND HOUR OF DEATH February 8, 1965 3:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex (21) D. STREET ADDRESS (If rural, give location) 811 Woodrow Avenue | | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH Nov. 19, 1923 | | 9. AGE (In years last birthday) 41 | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | | 11. UNDER 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | | | 10B. KIND OF BUSINESS OR INDUSTRY Plumbing & Heating Co. | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Daniel L. Firestone | | | | 14. MOTHER'S MAIDEN NAME Emma G. Alte | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | | | 16. SOCIAL SECURITY NO. 218-12-2205 | | 17. INFORMANT Beverly Bartholomew 811 Woodrow Ave. #21 | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO Hypertension - Coronary Occlusion (B) DUE TO Cardio Vascular - Coronary Disease (C) DUE TO Obesity | | | | INTERVAL BETWEEN ONSET AND DEATH Syn | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 23, 1964 to Feb 8, 1965, that (I) (we) last saw the deceased alive on Feb 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Michael Crossfeld | | | | M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 2-9-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Michael Crossfeld | | | | 23D. ADDRESS 5402 Belair Road Baltimore, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/11/65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 10 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | | 25C. FUNERAL DIRECTOR James E. Bruzdziński 1407 Eastern Ave. #21 | | | |

